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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

In addition to the changes adopted by agencies, the replacement chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to the divider tabs in the IAC binders. New and replacement chapters included in this Supplement are listed below. Carefully remove and insert chapters accordingly.

Editor's telephone (515)281-3355 or (515)242-6873

Human Services Department[441]

Replace Chapter 79

Environmental Protection Commission[567]

Replace Chapter 61

Public Safety Department[661]

Replace Chapter 502

Replace Chapter 552

Revenue Department[701]

Replace Analysis

Replace Chapter 151

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 20 percent of other costs.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) “e”(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider’s reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider’s actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 2.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital’s fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) “aa” and 79.1(16) “h.”

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) Basis of reimbursement of specific provider categories.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 11/30/09 less 5%. Air ambulance: Fee schedule in effect 11/30/09 less 5%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	\$50.57 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/11.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 11/30/09 less 5%.
Family planning clinics	Fee schedule	Fee schedule in effect 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
HCBS waiver service providers, including:		3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
		Except as noted, limits apply to all waivers that cover the named provider.
	1. Adult day care	Fee schedule
		For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers effective 7/1/11: Provider's rate in effect 11/30/09. If no 11/30/09 rate: Veterans Administration contract rate or \$22.12 per half-day, \$44.03 per full day, or \$66.03 per extended day if no Veterans Administration contract.
		For intellectual disability waiver: County contract rate or, effective 7/1/11 in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate, \$29.47 per half-day, \$58.83 per full day, or \$75.00 per extended day.
2. Emergency response system:		
	Personal response system	Fee schedule
		Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Initial one-time fee: \$49.53. Ongoing monthly fee: \$38.52.
	Portable locator system	Fee schedule
		Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: One equipment purchase: \$307.69. Initial one-time fee: \$49.53. Ongoing monthly fee: \$38.52.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09.
		For intellectual disability waiver effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$19.81 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$82.92 per visit. For intellectual disability waiver effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$82.92 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate, not to exceed \$296.94 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate, not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed \$296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$33.75 per hour not to exceed \$296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$18.01 per hour not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed \$296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$33.75 per hour not to exceed \$296.94 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$18.01 per hour not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed \$296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed the facility's daily Medicaid rate.
Camps	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed \$296.94 per day.
Adult day care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with mental retardation	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$7.71 per half hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
8. Home-delivered meals	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$7.71 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver: \$1,010 lifetime maximum. For intellectual disability waiver: \$5,050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: \$6,060 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	Effective 7/1/11: County contract rate or, in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	Effective 7/1/11 for non-county contract: Provider's rate in effect 11/30/09. If no 11/30/09 rate: \$8.25 per unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/11: \$110.05 per unit.
14. Senior companion	Fee schedule	Effective 7/1/11 for non-county contract: Provider's rate in effect 11/30/09. If no 11/30/09 rate: \$6.59 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$20.20 per hour not to exceed \$116.72 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$1,117 per calendar month. When prorated per day for a partial month, \$36.71 per day.
Individual	Fee agreed upon by member and provider	Effective July 1, 2010, \$13.47 per hour not to exceed \$78.56 per day.
16. Counseling		
Individual:	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$10.79 per unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Group:	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$43.14 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1) "d."	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: \$34.98 per hour, \$78.88 per day not to exceed the maximum daily ICF/MR rate.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: \$34.98 per hour. Maximum of 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: \$34.98 per hour for all activities other than personal care and services in an enclave setting. \$19.81 per hour for personal care. \$6.19 per hour for services in an enclave setting. \$2,883.71 per month for total service. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	\$6,060 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$10.79 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$43.14 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
23. Prevocational services	Fee schedule	For the brain injury waiver effective 7/1/11: \$48.22 per day, \$24.11 per half-day, or \$13.21 per hour. For the intellectual disability waiver effective 7/1/11: County contract rate or, in absence of a contract rate, \$48.22 per day, \$24.11 per half-day, or \$13.21 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
Child development home or center	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour.
Supported community living provider	Retrospectively limited prospective rate	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$34.98 per hour, not to exceed the maximum ICF/MR rate per day.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: The maximum ICF/MR rate per day.
26. Day habilitation	Fee schedule	Effective 7/1/11: County contract rate or, in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.21 per hour, \$32.15 per half-day, or \$64.29 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	\$6,060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$34.98 per hour.
29. In-home family therapy	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$93.63 per hour.
30. Financial management services	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$65.65 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$15.15 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1) "d."	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	\$46.70 per hour or \$105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	\$13.21 per hour, \$32.15 per half-day, or \$64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	\$9.91 per hour, \$24.11 per half-day, or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of \$34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	\$6.19 per hour for services in an enclave setting; \$19.81 per hour for personal care; and \$34.98 per hour for all other services. Total not to exceed \$2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 11/30/09 less 5%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14) "d")
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1) "g" and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 11/30/09 less 5%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)“c”	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members. 2. Fee schedule for service provided for all other Medicaid members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 11/30/09 less 5%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)“d”(1)“1” and (2)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)“d”(1)“2” and (2)“2” is 96% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)“f.” The direct care rate component limit under 441—81.6(16)“f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)“f”(1) and (2) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)“d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)“d”(3)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)“f.” The direct care rate component limit under 441—81.6(16)“f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)“f”(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 11/30/09 less 5%.
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7) "a"	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	\$6.20 dispensing fee effective 8/1/11. (See 79.1(8) "a," "b," and "c.")
Psychiatric medical institutions for children		
1. Inpatient	Retrospective cost-related	Effective 8/1/11: Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa.
2. Outpatient day treatment	Fee schedule	Effective 8/1/11: Fee schedule in effect 11/30/09.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 11/30/09 less 5%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1) "d."	Retrospective cost-settled rate.

79.1(3) Ambulatory surgical centers.

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's Web site. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)“c”). This payment is made directly to the physician or dentist.

79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers. Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) Reimbursement for hospitals.

a. *Definitions.*

“*Adolescent*” shall mean a Medicaid patient 17 years or younger.

“*Adult*” shall mean a Medicaid patient 18 years or older.

“*Average daily rate*” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

“*Base year cost report*” means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5)“x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“*Blended base amount*” shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Blended capital costs*” shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Capital costs*” shall mean an add-on to the blended base amount, which shall compensate for Medicaid’s portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital’s base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“Case-mix adjusted” shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“Case-mix index” shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“Children’s hospitals” shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children’s hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and

2. Is a voting member of the National Association of Children’s Hospitals and Related Institutions.

“Cost outlier” shall mean cases which have an extraordinarily high cost as established in 79.1(5) “f,” so as to be eligible for additional payments above and beyond the initial DRG payment.

“Critical access hospital” or *“CAH”* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

“Diagnosis-related group (DRG)” shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

“Direct medical education costs” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital’s case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share payment” shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

“Disproportionate share percentage” shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital’s own Medicaid inpatient utilization rate

exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)“y”(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Disproportionate share rate*” shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

“*DRG weight*” shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

“*Final payment rate*” shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider’s reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

“*Full DRG transfer*” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“*GME/DSH fund apportionment claim set*” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“*GME/DSH fund implementation year*” means 2009.

“*Graduate medical education and disproportionate share fund*” or “*GME/DSH fund*” means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

“*Indirect medical education rate*” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“*Inlier*” shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

“*Long stay outlier*” shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)“f.”

“*Low-income utilization rate*” shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients

under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Medicaid inpatient utilization rate” shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Neonatal intensive care unit” shall mean a designated level II or level III neonatal unit.

“Net discharges” shall mean total discharges minus transfers and short stay outliers.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“Rate table listing” shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

“Rebasing” shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

“Rebasing implementation year” means 2008 and every three years thereafter.

“Recalibration” shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

“Short stay day outlier” shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*“f.”*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*“r.”* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*“r.”* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization.

The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. *Calculation of Iowa-specific weights and case-mix index.* From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. *Calculation of blended base amount.* The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical

rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)“r,” and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)“r,” which are paid per diem, as specified in paragraph 79.1(5)“i.”

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)“r” and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)“r” is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital’s base-year cost report pursuant to paragraph 79.1(5)“a.” No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)“j.”

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state’s fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare’s approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital’s reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing

implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)“y”(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph “y.”

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph 79.1(5)“y.” Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)“y.”

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph “f.”

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)"b"(1), a neonatal intensive care unit under subparagraph 79.1(5)"b"(2), a psychiatric unit under paragraph 79.1(5)"i," or a physical rehabilitation hospital or unit under paragraph 79.1(5)"i" shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)"b"(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)"b"(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals

certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5) “b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5) “i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5) “i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. *Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. *Limitations and application of limitations on payment.* Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider’s customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital’s fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable,

and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.
- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$8,210,006. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$14,415,396. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard

deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,890,959. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5) "u" or 79.1(5) "v" cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5) "a" to "z" are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5) "a" to "z." Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5) "k."

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

- | | |
|---|--|
| Y | The condition was present or developing at the time of the order for inpatient admission. |
| N | The condition was not present or developing at the time of the order for inpatient admission. |
| U | Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission. |
| W | Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission. |

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory

procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)“e” for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7)“a” shall be reduced by an adjustment factor as determined by the department. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following:

- (1) Hospital inpatient unit (POS 21).
- (2) Hospital outpatient unit (POS 22).
- (3) Hospital emergency room (POS 23).
- (4) Ambulatory surgical center (POS 24).
- (5) Skilled nursing facility (POS 31).
- (6) Inpatient psychiatric facility (POS 51).
- (7) Community mental health center (POS 53).
- (8) Comprehensive inpatient rehabilitation (POS 61).

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

- (1) The estimated acquisition cost, defined:

1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph “g”; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph “g.”

- (2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph “g.”

- (3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph “g.”

- (4) The submitted charge, representing the provider's usual and customary charge for the drug.

b. Reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

- (1) The estimated acquisition cost, defined:

1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph “g”; or

2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph “g.”

- (2) The submitted charge, representing the provider's usual and customary charge for the drug.

c. No payment shall be made for sales tax.

d. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu

of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph “a” except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

g. For services rendered on or after August 1, 2011, the professional dispensing fee is \$6.20 or the pharmacy’s usual and customary fee, whichever is lower.

h. For purposes of this subrule, “equivalent products” shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, “Approved Prescription Drug Products With Therapeutic Equivalence Evaluations.”

i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8) “a”(3) and 79.1(8) “c” and for the efficient operation of the pharmacy benefit.

(1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

(2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

j. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

79.1(9) HCBS consumer choices financial management.

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer’s individual budget amount as determined under 441—paragraph 78.34(13) “b,” 78.37(16) “b,” 78.38(9) “b,” 78.41(15) “b,” 78.43(15) “b,” or 78.46(6) “b.”

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to \$10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by member.* A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than \$25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is \$25.01 to \$50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is \$50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13) "k." This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in “1” and “2.”

4. Comparing the amount in “3” with interim payments made to the hospice for inpatient care during the “cap period.”

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

- (1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

- (2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

- (3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

- (4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

- (5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

- (6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

- (7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

- (8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

- (1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

- (2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

- (3) Indirect administrative costs shall be limited to 20 percent of other costs.

- (4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph "e."

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph "d."

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph "f."

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph "f."

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 102.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 102.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over

30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph "g" and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

"GME/DSH fund implementation year" means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“Healthcare common procedures coding system” or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“Hospital-based clinic” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“International classifications of diseases—fourth edition, ninth revision (ICD-9)” is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person’s injury or illness.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Modifier” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“Multiple significant procedure discounting” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“Observation services” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“Outpatient hospital services” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“Outpatient prospective payment system” or *“OPPS”* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“Outpatient visit” shall mean those hospital-based outpatient services which are billed on a single claim form.

“Packaged service” means a service that is secondary to other services but is considered an integral part of another service.

“Pass-through” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“Rebasing” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“Significant procedure” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular

OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as:</p> <ul style="list-style-type: none"> • Ambulance services. • Clinical diagnostic laboratory services. • Diagnostic mammography. • Screening mammography. • Nonimplantable prosthetic and orthotic devices. • Physical, occupational, and speech therapy. • Erythropoietin for end-stage renal dialysis (ESRD) patients. • Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPPS APC.</p> <ul style="list-style-type: none"> • May be paid when submitted on a different bill type other than outpatient hospital (13x). • An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> • That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or • For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.</p>
F	<p>Certified registered nurse anesthetist services</p> <p>Corneal tissue acquisition</p> <p>Hepatitis B vaccines</p>	<p>If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>

G	Pass-through drugs and biologicals	<p>If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
H	Pass-through device categories	<p>If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.</p>
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	<p>If covered by Iowa Medicaid, the item is:</p> <ul style="list-style-type: none"> • Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. • Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c" when either no APC or APC weight is established. <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
L	Influenza vaccine Pneumococcal pneumonia vaccine	<p>If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.</p>
M	Items and services not billable to the Medicare fiscal intermediary	<p>If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," "V," or "X." • In all other circumstances, payment is made through a separate APC payment.

Q2	T-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” • In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>

Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
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d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs "g" to "n."

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs "g" to "n," for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. *Cost outlier payment policy.* Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. *Payment to critical access hospitals.* Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. *Cost-reporting requirements.* Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. *Rebasing.*

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room and on whether the member is participating in the MediPASS program.

1. For members not participating in the MediPASS program who were referred to the emergency room by appropriate medical personnel and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members not participating in the MediPASS program who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

3. For members participating in the MediPASS program who were not referred to the emergency room by their MediPASS primary care physician, no payment will be made for treatment provided in the emergency room.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993.

Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,776,336. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall

request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims for inpatient and outpatient hospital services.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. *Definitions.* For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicaid reimbursement" means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. *Reimbursement of crossover claims.* Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. *Additional Medicaid payment for crossover claims uncollectible from Medicare.* Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph "b" and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph "b." The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. *Application of savings.* Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23) "c"(1). The unit

of service may be a quarter-hour, a half-hour, an hour, a half-day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23) "c"(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1) "d." Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

- (3) A unit of day habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).
- (4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).
- (5) A unit of supported employment habilitation for activities to obtain a job is:
 1. One job placement for job development and employer development.
 2. One hour for enhanced job search.
- (6) A unit of supported employment habilitation supports to maintain employment is one hour.
 - b. Submission of cost reports.* The department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.
 - (1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.
 - (2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.
 - (3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.
 - (4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.
 - (5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.
 - (6) If a provider fails to submit a cost report that meets the requirement of paragraph 79.1(24) "b," the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.
 - (7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.
 - c. Rate determination based on cost reports.* Reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.
 - (1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.
 - (2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).
 - (3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the

amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(25) *Reimbursement for community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled into the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7835B, IAB 6/3/09, effective 7/8/09; ARC 7937B, IAB 7/1/09, effective 7/1/09; ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 8206B, IAB 10/7/09, effective 11/11/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8647B, IAB 4/7/10, effective 3/11/10; ARC 8649B, IAB 4/7/10, effective 3/11/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 8899B, IAB 6/30/10, effective 7/1/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9134B, IAB 10/6/10, effective 10/1/10; ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9176B, IAB 11/3/10, effective 12/8/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 9706B, IAB 9/7/11, effective 8/17/11; ARC 9708B, IAB 9/7/11, effective 8/17/11; ARC 9710B, IAB 9/7/11, effective 8/17/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9712B, IAB 9/7/11, effective 9/1/11; ARC 9714B, IAB 9/7/11, effective 9/1/11; ARC 9719B, IAB 9/7/11, effective 9/1/11; ARC 9722B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 9886B, IAB 11/30/11, effective 1/4/12; ARC 9887B, IAB 11/30/11, effective 1/4/12; ARC 9958B, IAB 1/11/12, effective 2/15/12; ARC 9959B, IAB 1/11/12, effective 2/15/12; ARC 9960B, IAB 1/11/12, effective 2/15/12; ARC 9966B, IAB 2/8/12, effective 1/19/12; ARC 0028C, IAB 3/7/12, effective 4/11/12; ARC 0029C, IAB 3/7/12, effective 4/11/12; ARC 9959B nullified (See nullification note at end of chapter)]

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) Definitions.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the withholding of all payments due a provider until the resolution of the matter in dispute between the provider and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) Grounds for sanctioning providers. Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

- e.* Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.
- f.* Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.
- g.* Failure to comply with the terms of the provider certification on each medical assistance check endorsement.
- h.* Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.
- i.* Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.
- j.* Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.
- k.* Submission of a false or fraudulent application for provider status under the medical assistance program.
- l.* Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.
- m.* Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.
- n.* Failure to meet standards required by state or federal law for participation, for example, licensure.
- o.* Exclusion from Medicare because of fraudulent or abusive practices.
- p.* Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.
- q.* Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.
- r.* Formal reprimand or censure by an association of the provider's peers for unethical practices.
- s.* Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.
- t.* Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

79.2(3) Sanctions. The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

- a.* A term of probation for participation in the medical assistance program.
- b.* Termination from participation in the medical assistance program.
- c.* Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.
- d.* Suspension or withholding of payments to provider.
- e.* Referral to peer review.
- f.* Prior authorization of services.
- g.* One hundred percent review of the provider's claims prior to payment.
- h.* Referral to the state licensing board for investigation.
- i.* Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.
- j.* Providers with a total Medicaid credit balance of more than \$500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over \$500.

Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Iowa Medicaid enterprise. Overpayments and interest charged may be withheld from future payments to the provider.

79.2(4) *Imposition and extent of sanction.*

a. The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.

b. The following factors shall be considered in determining the sanction or sanctions to be imposed:

- (1) Seriousness of the offense.
- (2) Extent of violations.
- (3) History of prior violations.
- (4) Prior imposition of sanctions.
- (5) Prior provision of provider education.
- (6) Provider willingness to obey program rules.
- (7) Whether a lesser sanction will be sufficient to remedy the problem.
- (8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from participation shall preclude the provider from submitting claims for payment, whether personally or through claims submitted by any clinic, group, corporation, or other association, for any services or supplies except for those services provided before the suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payment for any services or supplies provided by a person within the organization who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

d. When the provisions of paragraph 79.2(5) "c" are violated by a provider of services which is a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

79.2(6) *Notice of sanction.* When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

79.2(7) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

- a. The nature of the discrepancies or violations,
- b. The known dollar value of the discrepancies or violations,
- c. The method of computing the dollar value,
- d. Notification of further actions to be taken or sanctions to be imposed by the department, and
- e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

79.2(8) *Suspension or withholding of payments pending a final determination.* Where the department has notified a provider of a violation pursuant to 79.2(7) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a

final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

This rule is intended to implement Iowa Code section 249A.4.

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request may result in claim denial or recoupment.

79.3(1) Financial (fiscal) records.

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program.

These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

b. Purpose. The medical record shall provide evidence that the service provided is:

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. Components.

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) "d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.

2. The member's medical or social history.

3. Examination findings.

4. Diagnostic test reports, laboratory test results, or X-ray reports.

5. Goals or needs identified in the member's plan of care.

6. Physician orders and any prior authorizations required for Medicaid payment.

7. Medication records, pharmacy records for prescriptions, or providers' orders.

8. Related professional consultation reports.

9. Progress or status notes for the services or activities provided.

10. All forms required by the department as a condition of payment for the services provided.

11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.

12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5) “c” or “d,” 441—paragraph 77.33(6) “d,” 441—paragraph 77.34(5) “d,” 441—paragraph 77.37(15) “d,” 441—paragraph 77.39(13) “e,” 441—paragraph 77.39(14) “d,” or 441—paragraph 77.46(5) “i,” or 441—subparagraph 78.9(10) “a”(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2) “b.”)

- (1) Physician (MD and DO) services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
- (2) Pharmacy services:
 1. Prescriptions.
 2. Nursing facility physician order.
 3. Telephone order.
 4. Pharmacy notes.
 5. Prior authorization documentation.
- (3) Dentist services:
 1. Treatment notes.
 2. Anesthesia notes and records.
 3. Prescriptions.
- (4) Podiatrist services:
 1. Service or office notes or narratives.
 2. Certifying physician statement.
 3. Prescription or order form.

- (5) Certified registered nurse anesthetist services:
 - 1. Service notes or narratives.
 - 2. Preanesthesia physical examination report.
 - 3. Operative report.
 - 4. Anesthesia record.
 - 5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
 - 1. Service or office notes or narratives.
 - 2. Procedure, laboratory, or test orders and results.
- (7) Optometrist and optician services:
 - 1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
 - 2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
 - 3. Prior authorization documentation.
- (8) Psychologist services:
 - 1. Service or office psychotherapy notes or narratives.
 - 2. Psychological examination report and notes.
- (9) Clinic services:
 - 1. Service or office notes or narratives.
 - 2. Procedure, laboratory, or test orders and results.
 - 3. Nurses' notes.
 - 4. Prescriptions.
 - 5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 - 1. Service or office notes or narratives.
 - 2. Form 470-2942, Prenatal Risk Assessment.
 - 3. Procedure, laboratory, or test orders and results.
 - 4. Immunization records.
- (11) Services provided by community mental health centers:
 - 1. Service referral documentation.
 - 2. Initial evaluation.
 - 3. Individual treatment plan.
 - 4. Service or office notes or narratives.
 - 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
 - 6. Written plan for accessing emergency services.
- (12) Screening center services:
 - 1. Service or office notes or narratives.
 - 2. Immunization records.
 - 3. Laboratory reports.
 - 4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
 - 1. Service or office notes or narratives.
 - 2. Procedure, laboratory, or test orders and results.
 - 3. Nurses' notes.
 - 4. Immunization records.
 - 5. Consent forms.
 - 6. Prescriptions.
 - 7. Medication administration records.
- (14) Maternal health center services:
 - 1. Service or office notes or narratives.
 - 2. Procedure, laboratory, or test orders and results.
 - 3. Form 470-2942, Prenatal Risk Assessment.

- (15) Birthing center services:
 - 1. Service or office notes or narratives.
 - 2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
 - 1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 - 2. Physician orders.
 - 3. Consent forms.
 - 4. Anesthesia records.
 - 5. Pathology reports.
 - 6. Laboratory and X-ray reports.
- (17) Hospital services:
 - 1. Physician orders.
 - 2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 - 3. Progress or status notes.
 - 4. Diagnostic procedures, including laboratory and X-ray reports.
 - 5. Pathology reports.
 - 6. Anesthesia records.
 - 7. Medication administration records.
- (18) State mental hospital services:
 - 1. Service referral documentation.
 - 2. Resident assessment and initial evaluation.
 - 3. Individual comprehensive treatment plan.
 - 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 - 5. Form 470-0042, Case Activity Report.
 - 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
 - 1. Physician orders.
 - 2. Progress or status notes.
 - 3. Service notes or narratives.
 - 4. Procedure, laboratory, or test orders and results.
 - 5. Nurses' notes.
 - 6. Physical therapy, occupational therapy, and speech therapy notes.
 - 7. Medication administration records.
 - 8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:
 - 1. Physician orders.
 - 2. Progress or status notes.
 - 3. Preliminary evaluation.
 - 4. Comprehensive functional assessment.
 - 5. Individual program plan.
 - 6. Form 470-0374, Resident Care Agreement.
 - 7. Program documentation.
 - 8. Medication administration records.
 - 9. Nurses' notes.
 - 10. Form 470-0042, Case Activity Report.
- (21) Services provided by psychiatric medical institutions for children:
 - 1. Physician orders or court orders.
 - 2. Independent assessment.
 - 3. Individual treatment plan.

4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.
- (22) Hospice services:
 1. Physician certifications for hospice care.
 2. Form 470-2618, Election of Medicaid Hospice Benefit.
 3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
 1. Physician orders.
 2. Initial certification, recertifications, and treatment plans.
 3. Narratives from treatment sessions.
 4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
 1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
- (25) Behavioral health intervention:
 1. Order for services.
 2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
- (26) Services provided by area education agencies and local education agencies:
 1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:
 1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
- (28) Services provided by independent laboratories:
 1. Laboratory reports.
 2. Physician order for each laboratory test.
- (29) Ambulance services:
 1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
 1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.
- (31) Medical supplies:
 1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.

4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
 1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
 1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
 2. Notice of decision for service authorization.
 3. Service notes or narratives.
 4. Social history.
 5. Comprehensive service plan.
 6. Reassessment of member needs.
 7. Incident reports in accordance with 441—subrule 24.4(5).
- (34) Early access service coordinator services:
 1. Individualized family service plan (IFSP).
 2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
 1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.
 6. Invoices or receipts.
 7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
- (36) Physical therapist services:
 1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.
- (37) Chiropractor services:
 1. Service or office notes or narratives.
 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
 1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
 2. Documentation of hearing aid evaluation and selection (Form 470-0828).
 3. Waiver of informed consent.
 4. Prior authorization documentation.
 5. Service or office notes or narratives.
- (39) Behavioral health services:
 1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
- e. *Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.
 - (1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.
 - (2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) Maintenance requirement. The provider shall maintain records as required by this rule:

- a. During the time the member is receiving services from the provider.
- b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
- c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) Availability. Rescinded IAB 1/30/08, effective 4/1/08.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

“Authorized representative,” within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

“Claim” means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

“Clinical record” means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

“Confidence level” means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“Customary and prevailing fee” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“Extrapolation” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“Fiscal record” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“Overpayment” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“Procedure code” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“Random sample” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“Underpayment” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“Universe” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) Audit or review of clinical and fiscal records by the department. Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided, in the following format:

Iowa Department of Human Services
Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Documentation Checklist

Date of Request: _____
Reviewer Name & Phone Number: _____
Provider Name: _____
Provider Number: _____
Provider Type: _____

Please sign this form and return it with the information requested.

Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.

Please send copies. Do not send original records.

If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number
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470-4479 (4/08)

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) Audit or review procedures. The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph “b.”

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider's designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

- (1) Comparing clinical and fiscal records with each claim.
- (2) Interviewing members who received goods or services and employees of providers.
- (3) Examining third-party payment records.
- (4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.
- (5) Examining all documents related to the services for which Medicaid was billed.

e. *Use of statistical sampling techniques.* The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph “a” of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

c. Disagreement with sampling results. When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

This rule is intended to implement Iowa Code section 249A.4.

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department’s policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

This rule is intended to implement Iowa Code section 249A.4.

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers. Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) Membership. The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

79.7(3) Expenses, staff support, and technical assistance. Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) Meetings. The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) Procedures.

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) Duties.

a. Executive committee. Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

- (1) Advise the professional groups and business entities represented and act as liaison between them and the department.
- (2) Report at least annually to the professional groups and business entities represented.
- (3) Perform other functions as may be provided by state or federal law or regulation.
- (4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) Responsibilities.

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[ARC 8263B, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

This rule is intended to implement Iowa Code section 249A.4.

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.12(249A) Advance directives. “Advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person’s admission as an inpatient, a home health care provider in advance of a person’s coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person’s rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider’s policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person’s medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

This rule is intended to implement Iowa Code section 249A.4.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

This rule is intended to implement Iowa Code section 249A.4.

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

d. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) Policy requirements. Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1) "a";

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) Reporting requirements.

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) Enforcement. Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) State elections. In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as published in the Federal Register, Vol. 75, No. 144, on July 28, 2010. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to July 28, 2010, the department elects the calendar year preceding the payment year as the period used to calculate whether or not an eligible professional is “hospital-based” for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to July 28, 2010, eligible providers may elect to use either:

- (1) The methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010, or
- (2) The methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to July 28, 2010, the “12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to July 28, 2010, the “12-month period selected by the state” shall mean the hospital fiscal year.

79.16(2) Eligible providers. To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic

when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399.

(3) A children’s hospital, defined as a separately certified children’s hospital, either freestanding or a hospital-within-hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional’s patient volume covered by Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a “pediatrician” is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the National Level Repository, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider’s application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the EHR incentive payment program section of the Iowa

Medicaid portal access (IMPA) Web site at <https://secureapp.dhs.state.ia.us/imp/>. The applicant shall use the Web site to:

- (1) Attest to the applicant's qualifications to receive the incentive payment, and
- (2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, the eligible provider must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) Payment. The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the National Level Repository.

a. The primary communication channel from the department to the provider will be the IMPA Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

- (1) Eligibility,
- (2) Purchase of certified electronic health record technology, and
- (3) Meaningful use of electronic health record technology.

79.16(5) Administrative appeal. Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a.* Provider eligibility determination.
- b.* Incentive payments.
- c.* Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

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⁰ Two or more ARCs

¹ Effective date of 79.1(2) and 79.1(5) "t" delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

³ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

⁴ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

⁶ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.

⁷ July 1, 2009, effective date of amendments to 79.1(1) "d," 79.1(2), and 79.1(24) "a"(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

⁸ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) "b" (ARC 9959B, IAB 1/11/12).

CHAPTER 61 WATER QUALITY STANDARDS

[Prior to 7/1/83, DEQ Ch 16]

[Prior to 12/3/86, Water, Air and Waste Management[900]]

WATER QUALITY STANDARDS

567—61.1 Rescinded, effective August 31, 1977.

567—61.2(455B) General considerations.

61.2(1) Policy statement. It shall be the policy of the commission to protect and enhance the quality of all the waters of the state. In the furtherance of this policy it will attempt to prevent and abate the pollution of all waters to the fullest extent possible consistent with statutory and technological limitations. This policy shall apply to all point and nonpoint sources of pollution.

These water quality standards establish selected criteria for certain present and future designated uses of the surface waters of the state. The standards establish the areas where these uses are to be protected and provide minimum criteria for waterways having nondesignated uses as well. Many surface waters are designated for more than one use. In these cases the more stringent criteria shall govern for each parameter.

Certain of the criteria are in narrative form without numeric limitations. In applying such narrative standards, decisions will be based on the U.S. Environmental Protection Agency's methodology described in "Guidelines for Deriving Numerical National Water Quality Criteria for the Protection of Aquatic Organisms and Their Uses," (1985) and on the rationale contained in "Quality Criteria for Water," published by the U.S. Environmental Protection Agency (1977), as updated by supplemental Section 304 (of the Act) Ambient Water Quality Criteria documents. To provide human health criteria for parameters not having numerical values listed in 61.3(3) Table 1, the required criteria will be based on the rationale contained in these EPA criteria documents. The human health criterion considered will be the value associated with the consumption of fish flesh and a risk factor of 10^{-5} for carcinogenic parameters. For noncarcinogenic parameters, the recommended EPA criterion will be selected. For Class C water, the EPA criteria for fish and water consumption will be selected using the same considerations for carcinogenic and noncarcinogenic parameters as noted above.

All methods of sample collection, preservation, and analysis used in applying any of the rules in these standards shall be in accord with those prescribed in 567—Chapter 63.

61.2(2) Antidegradation policy. It is the policy of the state of Iowa that:

a. Tier 1 protection. Existing surface water uses and the level of water quality necessary to protect the existing uses will be maintained and protected.

b. Tier 2 protection. Where the quality of the waters exceeds levels necessary to support propagation of fish, shellfish, and wildlife and recreation in and on the water, that quality shall be maintained and protected unless the department finds, after full satisfaction of the intergovernmental coordination and public participation provisions, that allowing lower water quality is necessary to accommodate important economic or social development in the area in which the waters are located. In allowing such degradation or lower water quality, the department shall ensure water quality adequate to protect existing uses fully. Further, the department shall ensure the highest statutory and regulatory requirements for all new and existing point sources and all cost-effective and reasonable best management practices for nonpoint source control before allowing any lowering of water quality.

c. Tier 2½ protection—outstanding Iowa waters. Where high quality waters constitute an outstanding state resource, such as waters of exceptional recreational or ecological significance, that water quality shall be maintained and protected.

d. Tier 3 protection—outstanding national resource waters. Where high quality waters constitute an outstanding national resource, such as waters of national and state parks and wildlife refuges and waters of exceptional recreational or ecological significance, that water quality shall be maintained and protected. Any proposed activity that would result in a permanent new or expanded source of pollutants in an outstanding national resource water is prohibited.

e. The four levels of protection provided by the antidegradation policy in paragraphs “a” through “d” of this subrule shall be implemented according to procedures hereby incorporated by reference and known as the “Iowa Antidegradation Implementation Procedure,” effective February 17, 2010. This document may be obtained on the department’s Web site at <http://www.iowadnr.com/water/standards/index.html>.

f. All unapproved facility plans for new or expanded construction permits, except for construction permits issued for nondischarging facilities, shall undergo an antidegradation review if degradation is likely in the receiving water or downstream waters following February 17, 2010.

g. This policy shall be applied in conjunction with water quality certification review pursuant to Section 401 of the Act. In the event that activities are specifically exempted from flood plain development permits or any other permits issued by this department in 567—Chapters 70, 71, and 72, the activity will be considered consistent with this policy. Other activities not otherwise exempted will be subject to 567—Chapters 70, 71, and 72 and this policy. United States Army Corps of Engineers (Corps) nationwide permits 3, 4, 5, 6, 7, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 25, 27, 29, 30, 31, 32, 33, 34, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 48, 49, 50, 51, and 52 as well as Corps regional permits 7, 27, 33, and 34 as promulgated June 20, 2012, are certified pursuant to Section 401 of the Clean Water Act subject to the following Corps regional conditions and the state water quality conditions:

(1) Side slopes of a newly constructed channel will be no steeper than 2:1 and planted to permanent, perennial, native vegetation if not armored.

(2) Nationwide permits with mitigation may require recording of the nationwide permit and pertinent drawings with the registrar of deeds or other appropriate official charged with the responsibility for maintaining records of title to, or interest in, real property and may also require the permittee to provide proof of that recording to the Corps.

(3) Mitigation shall be scheduled prior to, or concurrent with, the discharge of dredged or fill material into waters of the United States.

(4) For newly constructed channels through areas that are unvegetated, native grass filter strips, or a riparian buffer with native trees or shrubs a minimum of 35 feet wide from the top of the bank must be planted along both sides of the new channel. A survival rate of 80 percent of desirable species shall be achieved within three years of establishment of the buffer strip.

(5) For single-family residences authorized under nationwide permit 29, the permanent loss of waters of the United States (including jurisdictional wetlands) must not exceed 1/4 acre.

(6) For nationwide permit 46, the discharge of dredged or fill material into ditches that would sever the jurisdiction of an upstream water of the United States from a downstream water of the United States is not allowed.

(7) For projects that impact an outstanding national resource water, outstanding Iowa water, fens, bogs, seeps, or sedge meadows, an individual Section 401 Water Quality Certification will be required (Iowa Section 401 Water Quality Certification condition).

(8) For nationwide permits when the Corps’ district engineer has issued a waiver to allow the permittee to exceed the limits of the nationwide permit, an individual Section 401 Water Quality Certification will be required (Iowa Section 401 Water Quality Certification condition).

(9) Heavy equipment shall not be used or operated within the stream channel. If in-stream work is unavoidable, it shall be performed in such a manner as to minimize the duration of the disturbance, turbidity increases, substrate disturbance, bank disturbance, and disturbance to riparian vegetation. This condition does not further restrict otherwise authorized drainage ditch maintenance activities (Iowa Section 401 Water Quality Certification condition).

Written verification by the Corps or 401 certification by the state is required for activities covered by these permits as required by the nationwide permits or the Corps, and the activities are allowed subject to the terms and conditions of the nationwide and regional permits. The department will maintain and periodically update a guidance document listing special waters of concern. This document will be provided to the Corps for use in determining whether preconstruction notices should be provided to the department and other interested parties prior to taking action on applications for projects that would

normally be covered by a nationwide or regional permit and not require a preconstruction notice under nationwide permit conditions.

61.2(3) *Minimum treatment required.* All wastes discharged to the waters of the state must be of such quality that the discharge will not cause the narrative or numeric criteria limitations to be exceeded. Where the receiving waters provide sufficient assimilative capacity that the water quality standards are not the limiting factor, all point source wastes shall receive treatment in compliance with minimum effluent standards as adopted in rules by the department.

There are numerous parameters of water quality associated with nonpoint source runoff which are of significance to the designated water uses specified in the general and specific designations in 567—61.3(455B), but which are not delineated. It shall be the intent of these standards that the limits on such nonpoint source related parameters when adopted shall be those that can be achieved by best management practices as defined in the course of the continuing planning process from time to time. Existing water quality and nonpoint source runoff control technology will be evaluated in the course of the Iowa continuing planning process, and best management practices and limitations on specific water quality parameters will be reviewed and revised from time to time to ensure that the designated water uses and water quality enhancement goals are met.

61.2(4) *Regulatory mixing zones.* Mixing zones are recognized as being necessary for the initial assimilation of point source discharges which have received the required degree of treatment or control. Mixing zones shall not be used for, or considered as, a substitute for minimum treatment technology required by subrule 61.2(3). The objective of establishing mixing zones is to provide a means of control over the placement and emission of point source discharges so as to minimize environmental impacts. Waters within a mixing zone shall meet the general water quality criteria of subrule 61.3(2). Waters at and beyond mixing zone boundaries shall meet all applicable standards and the chronic and human health criteria of subrule 61.3(3), Tables 1 and 3, for that particular water body or segment. A zone of initial dilution may be established within the mixing zone beyond which the applicable standards and the acute criteria of subrule 61.3(3) will be met. For waters designated under subrule 61.3(5), any parameter not included in Tables 1, 2 and 3 of subrule 61.3(3), the chronic and human health criteria, and the acute criterion calculated following subrule 61.2(1), will be met at the mixing zone and zone of initial dilution boundaries, respectively.

a. Due to extreme variations in wastewater and receiving water characteristics, spatial dimensions of mixing zones shall be defined on a site-specific basis. These rules are not intended to define each individual mixing zone, but will set maximum limits which will satisfy most biological, chemical, physical and radiological considerations in defining a particular mixing zone. Additional details are noted in the “Supporting Document for Iowa Water Quality Management Plans,” Chapter IV, July 1976, as revised on November 11, 2009, for considering unusual site-specific features such as side channels and sand bars which may influence a mixing zone. Applications for operation permits under 567—subrule 64.3(1) may be required to provide specific information related to the mixing zone characteristics below their outfall so that mixing zone boundaries can be determined.

b. For parameters included in Table 1 only (which does not include ammonia nitrogen), the dimensions of the mixing zone and the zone of initial dilution will be calculated using a mathematical model presented in the “Supporting Document for Iowa Water Quality Management Plans,” Chapter IV, July 1976, as revised on November 11, 2009, or from instream studies of the mixing characteristics during low flow. In addition, the most restrictive of the following factors will be met:

(1) The stream flow in the mixing zone may not exceed the most restrictive of the following:

1. Twenty-five percent of the design low stream flows noted in subrule 61.2(5) for interior streams and rivers, and the Big Sioux and Des Moines Rivers.

2. Ten percent of the design low stream flows noted in subrule 61.2(5) for the Mississippi and Missouri Rivers.

3. The stream flow contained in the mixing zone at the most restrictive of the applicable mixing zone length criteria, noted below.

(2) The length of the mixing zone below the point of discharge shall be set by the most restrictive of the following:

1. The distance to the juncture of two perennial streams.
2. The distance to a public water supply intake.
3. The distance to the upstream limits of an established recreational area, such as public beaches, and state, county and local parks.
4. The distance to the middle of a crossover point in a stream where the main current flows from one bank across to the opposite bank.
5. The distance to another mixing zone.
6. Not to exceed a distance of 2000 feet.
7. The location where the mixing zone contained the percentages of stream flow noted in 61.2(4) "b"(1).

(3) The width of the mixing zone is calculated as the portion of the stream containing the allowed mixing zone stream flow. The mixing zone width will be measured perpendicular to the basic direction of stream flow at the downstream boundary of the mixing zone. This measurement will only consider the distance of continuous water surface.

(4) The width and length of the zone of initial dilution may not exceed 10 percent of the width and length of the mixing zone.

c. The stream flow used in determining wasteload allocations to ensure compliance with the maximum contaminant level (MCL), chronic and human health criteria of Table 1 will be that value contained at the boundary of the allowed mixing zone. This stream flow may not exceed the following percentages of the design low stream flow as measured at the point of discharge:

- (1) Twenty-five percent for interior streams and rivers, and the Big Sioux and Des Moines Rivers.
- (2) Ten percent for the Mississippi and Missouri Rivers.

The stream flow in the zone of initial dilution used in determining effluent limits to ensure compliance with the acute criteria of Table 1 may not exceed 10 percent of the calculated flow associated with the mixing zone.

d. For toxic parameters noted in Table 1, the following exceptions apply to the mixing zone requirements:

(1) No mixing zone or zone of initial dilution will be allowed for waters designated as lakes or wetlands.

(2) No zone of initial dilution will be allowed in waters designated as cold water.

(3) The use of a diffuser device to promote rapid mixing of an effluent in a receiving stream will be considered on a case-by-case basis with its usage as a means for dischargers to comply with an acute numerical criterion.

(4) A discharger to interior streams and rivers, the Big Sioux and Des Moines Rivers, and the Mississippi or Missouri Rivers may provide to the department, for consideration, instream data which technically supports the allowance of an increased percentage of the stream flow contained in the mixing zone due to rapid and complete mixing. Any allowed increase in mixing zone flow would still be governed by the mixing zone length restrictions. The submission of data should follow the guidance provided in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

e. For ammonia criteria noted in Table 3, the dimensions of the mixing zone and the zone of initial dilution will be calculated using a mathematical model presented in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009, or from instream studies of the mixing characteristics during low flow. In addition, the most restrictive of the following factors will be met:

(1) The stream flow in the mixing zone may not exceed the most restrictive of the following:

1. One hundred percent of the design low stream flows noted in subrule 61.2(5) for locations where the dilution ratio is less than or equal to 2:1.

2. Fifty percent of the design low stream flows noted in subrule 61.2(5) for locations where the dilution ratio is greater than 2:1, but less than or equal to 5:1.

3. Twenty-five percent of the design low stream flows noted in subrule 61.2(5) for locations where the dilution ratio is greater than 5:1.

4. The stream flow contained in the mixing zone at the most restrictive of the applicable mixing zone length criteria, noted below.

(2) The length of the mixing zone below the point of discharge shall be set by the most restrictive of the following:

1. The distance to the juncture of two perennial streams.
2. The distance to a public water supply intake.
3. The distance to the upstream limits of an established recreational area, such as public beaches, and state, county, and local parks.
4. The distance to the middle of a crossover point in a stream where the main current flows from one bank across to the opposite bank.
5. The distance to another mixing zone.
6. Not to exceed a distance of 2000 feet.
7. The location where the mixing zone contained the percentages of stream flow noted in 61.2(4) "e"(1).

(3) The width of the mixing zone is calculated as the portion of the stream containing the allowed mixing zone stream flow. The mixing zone width will be measured perpendicular to the basic direction of stream flow at the downstream boundary of the mixing zone. This measurement will only consider the distance of continuous water surface.

(4) The width and length of the zone of initial dilution may not exceed 10 percent of the width and length of the mixing zone.

f. For ammonia criteria noted in Table 3, the stream flow used in determining wasteload allocations to ensure compliance with the chronic criteria of Table 3 will be that value contained at the boundary of the allowed mixing zone. This stream flow may not exceed the percentages of the design low stream flow noted in 61.2(4) "e"(1) as measured at the point of discharge.

The pH and temperature values at the boundary of the mixing zone used to select the chronic ammonia criteria of Table 3 will be from one of the following sources. The source of the pH and temperature data will follow the sequence listed below, if applicable data exists from the source.

(1) Specific pH and temperature data provided by the applicant gathered at their mixing zone boundary. Procedures for obtaining this data are noted in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

(2) Regional background pH and temperature data provided by the applicant gathered along the receiving stream and representative of the background conditions at the outfall. Procedures for obtaining this data are noted in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

(3) The statewide average background values presented in Table IV-2 of the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

The stream flow in the zone of initial dilution used in determining effluent limits to ensure compliance with the acute criteria of Table 3 may not exceed 5 percent of the calculated flow associated with the mixing zone for facilities with a dilution ratio of less than or equal to 2:1, and not exceed 10 percent of the calculated flow associated with the mixing zone for facilities with a dilution ratio of greater than 2:1. The pH and temperature values at the boundary of the zone of initial dilution used to select the acute ammonia criteria of Table 3 will be from one of the following sources and follow the sequence listed below, if applicable data exists from the source.

1. Specific effluent pH and temperature data if the dilution ratio is less than or equal to 2:1.
2. If the dilution ratio is greater than 2:1, the logarithmic average pH of the effluent and the regional or statewide pH provided in 61.2(4) "f" will be used. In addition, the flow proportioned average temperature of the effluent and the regional or statewide temperature provided in 61.2(4) "f" will be used. The procedures for calculating these data are noted in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

g. For ammonia criteria noted in Table 3, the following exceptions apply to the mixing zone requirements.

(1) No mixing zone or zone of initial dilution will be allowed for waters designated as lakes or wetlands.

(2) No zone of initial dilution will be allowed in waters designated as cold water.

(3) The use of a diffuser device to promote rapid mixing of an effluent in a receiving stream will be considered on a case-by-case basis with its usage as a means for dischargers to comply with an acute numerical criterion.

(4) A discharger to interior streams and rivers, the Big Sioux and Des Moines Rivers, and the Mississippi and Missouri Rivers may provide to the department, for consideration, instream data which technically supports the allowance of an increased percentage of the stream flow contained in the mixing zone due to rapid and complete mixing. Any allowed increase in mixing zone flow would still be governed by the mixing zone length restrictions. The submission of data should follow the guidance provided in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

h. Temperature changes within mixing zones established for heat dissipation will not exceed the temperature criteria in 61.3(3) "b"(5).

i. The appropriateness of establishing a mixing zone where a substance discharged is bioaccumulative, persistent, carcinogenic, mutagenic, or teratogenic will be carefully evaluated. In such cases, effects such as potential groundwater contamination, sediment deposition, fish attraction, bioaccumulation in aquatic life, bioconcentration in the food chain, and known or predicted safe exposure levels shall be considered.

61.2(5) Implementation strategy. Numerical criteria specified in these water quality standards shall be met when the flow of the receiving stream equals or exceeds the design low flows noted below.

Type of Numerical Criteria	Design Low Flow Regime
Aquatic Life Protection (TOXICS)	
Acute	1Q ₁₀
Chronic	7Q ₁₀
Aquatic Life Protection (AMMONIA - N)	
Acute	1Q ₁₀
Chronic	30Q ₁₀
Human Health Protection & MCL	
Noncarcinogenic	30Q ₅
Carcinogenic	Harmonic mean

a. The allowable 3°C temperature increase criterion for warm water interior streams, 61.3(3) "b"(5) "1," is based in part on the need to protect fish from cold shock due to rapid cessation of heat source and resultant return of the receiving stream temperature to natural background temperature. On low flow streams, in winter, during certain conditions of relatively cold background stream temperature and relatively warm ambient air and groundwater temperature, certain wastewater treatment plants with relatively constant flow and constant temperature discharges will cause temperature increases in the receiving stream greater than allowed in 61.3(3) "b"(5) "1."

b. During the period November 1 to March 31, for the purpose of applying the 3°C temperature increase criterion, the minimum protected receiving stream flow rate below such discharges may be increased to not more than three times the rate of flow of the discharge, where there is reasonable assurance that the discharge is of such constant temperature and flow rate and continuous duration as to not constitute a threat of heat cessation and not cause the receiving stream temperature to vary more than 3°C per day.

c. Site-specific water quality criteria may be allowed in lieu of the specific numerical criteria listed in Tables 1 and 3 of this chapter if adequate documentation is provided to show that the proposed criteria will protect all existing or potential uses of the surface water. Site-specific water quality criteria may be appropriate where:

- (1) The types of organisms differ significantly from those used in setting the statewide criteria; or
- (2) The chemical characteristics of the surface water such as pH, temperature, and hardness differ significantly from the characteristics used in setting the statewide criteria.

Development of site-specific criteria shall include an evaluation of the chemical and biological characteristics of the water resource and an evaluation of the impact of the discharge. All evaluations for site-specific criteria modification must be coordinated through the department, and be conducted using scientifically accepted procedures approved by the department. Any site-specific criterion developed under the provisions of this subrule is subject to the review and approval of the U.S. Environmental Protection Agency. All criteria approved under the provisions of this subrule will be published periodically by the department. Guidelines for establishing site-specific water quality criteria can be found in "Water Quality Standards Handbook," published by the U.S. Environmental Protection Agency, December 1983.

d. A wastewater treatment facility may submit to the department technically valid instream data which provides additional information to be used in the calculations of their wasteload allocations and effluent limitations. This information would be in association with the low flow characteristics, width, length and time of travel associated with the mixing zone or decay rates of various effluent parameters. The wasteload allocation will be calculated considering the applicable data and consistent with the provisions and restrictions in the rules.

e. The department may perform use assessment and related use attainability analyses on water bodies where uses may not be known or adequately documented. The preparation of use attainability analysis documents will consider available U.S. Environmental Protection Agency guidance or other applicable guidance. Credible data and documentation will be used to assist in the preparation of use assessments and use attainability analysis reports.

[ARC 8214B, IAB 10/7/09, effective 11/11/09; ARC 8466B, IAB 1/13/10, effective 2/17/10; ARC 9330B, IAB 1/12/11, effective 2/16/11 (See Delay note at the end of chapter); ARC 0121C, IAB 5/16/12, effective 6/20/12]

567—61.3(455B) Surface water quality criteria.

61.3(1) *Surface water classification.* All waters of the state are classified for protection of beneficial uses. These classified waters include general use segments and designated use segments.

a. General use segments. These are intermittent watercourses and those watercourses which typically flow only for short periods of time following precipitation and whose channels are normally above the water table. These waters do not support a viable aquatic community during low flow and do not maintain pooled conditions during periods of no flow.

The general use segments are to be protected for livestock and wildlife watering, aquatic life, noncontact recreation, crop irrigation, and industrial, agricultural, domestic and other incidental water withdrawal uses.

b. Designated use segments. These are water bodies which maintain flow throughout the year or contain sufficient pooled areas during intermittent flow periods to maintain a viable aquatic community.

All perennial rivers and streams as identified by the U.S. Geological Survey 1:100,000 DLG Hydrography Data Map (published July 1993) or intermittent streams with perennial pools in Iowa not specifically listed in the surface water classification of 61.3(5) are designated as Class B(WW-1) waters.

All perennial rivers and streams as identified by the U.S. Geological Survey 1:100,000 DLG Hydrography Data Map (published July 1993) or intermittent streams with perennial pools in Iowa are designated as Class A1 waters.

Designated uses of segments may change based on a use attainability analysis consistent with 61.2(5) "e." Designated use changes will be specifically listed in the surface water classification of 61.3(5).

Designated use waters are to be protected for all uses of general use segments in addition to the specific uses assigned. Designated use segments include:

- (1) Primary contact recreational use (Class "A1"). Waters in which recreational or other uses may result in prolonged and direct contact with the water, involving considerable risk of ingesting water

in quantities sufficient to pose a health hazard. Such activities would include, but not be limited to, swimming, diving, water skiing, and water contact recreational canoeing.

(2) Secondary contact recreational use (Class “A2”). Waters in which recreational or other uses may result in contact with the water that is either incidental or accidental. During the recreational use, the probability of ingesting appreciable quantities of water is minimal. Class A2 uses include fishing, commercial and recreational boating, any limited contact incidental to shoreline activities and activities in which users do not swim or float in the water body while on a boating activity.

(3) Children’s recreational use (Class “A3”). Waters in which recreational uses by children are common. Class A3 waters are water bodies having definite banks and bed with visible evidence of the flow or occurrence of water. This type of use would primarily occur in urban or residential areas.

(4) Cold water aquatic life—Type 1 (Class “B(CW1)”). Waters in which the temperature and flow are suitable for the maintenance of a variety of cold water species, including reproducing and nonreproducing populations of trout (*Salmonidae* family) and associated aquatic communities.

(5) Cold water aquatic life—Type 2 (Class “B(CW2)”). Waters that include small, channeled streams, headwaters, and spring runs that possess natural cold water attributes of temperature and flow. These waters usually do not support consistent populations of trout (*Salmonidae* family), but may support associated vertebrate and invertebrate organisms.

(6) Warm water—Type 1 (Class “B(WW-1)”). Waters in which temperature, flow and other habitat characteristics are suitable to maintain warm water game fish populations along with a resident aquatic community that includes a variety of native nongame fish and invertebrate species. These waters generally include border rivers, large interior rivers, and the lower segments of medium-size tributary streams.

(7) Warm water—Type 2 (Class “B(WW-2)”). Waters in which flow or other physical characteristics are capable of supporting a resident aquatic community that includes a variety of native nongame fish and invertebrate species. The flow and other physical characteristics limit the maintenance of warm water game fish populations. These waters generally consist of small perennially flowing streams.

(8) Warm water—Type 3 (Class “B(WW-3)”). Waters in which flow persists during periods when antecedent soil moisture and groundwater discharge levels are adequate; however, aquatic habitat typically consists of nonflowing pools during dry periods of the year. These waters generally include small streams of marginally perennial aquatic habitat status. Such waters support a limited variety of native fish and invertebrate species that are adapted to survive in relatively harsh aquatic conditions.

(9) Lakes and wetlands (Class “B(LW)”). These are artificial and natural impoundments with hydraulic retention times and other physical and chemical characteristics suitable to maintain a balanced community normally associated with lake-like conditions.

(10) Human health (Class “HH”). Waters in which fish are routinely harvested for human consumption or waters both designated as a drinking water supply and in which fish are routinely harvested for human consumption.

(11) Drinking water supply (Class “C”). Waters which are used as a raw water source of potable water supply.

61.3(2) General water quality criteria. The following criteria are applicable to all surface waters including general use and designated use waters, at all places and at all times for the uses described in 61.3(1) “a.”

a. Such waters shall be free from substances attributable to point source wastewater discharges that will settle to form sludge deposits.

b. Such waters shall be free from floating debris, oil, grease, scum and other floating materials attributable to wastewater discharges or agricultural practices in amounts sufficient to create a nuisance.

c. Such waters shall be free from materials attributable to wastewater discharges or agricultural practices producing objectionable color, odor or other aesthetically objectionable conditions.

d. Such waters shall be free from substances attributable to wastewater discharges or agricultural practices in concentrations or combinations which are acutely toxic to human, animal, or plant life.

e. Such waters shall be free from substances, attributable to wastewater discharges or agricultural practices, in quantities which would produce undesirable or nuisance aquatic life.

f. The turbidity of the receiving water shall not be increased by more than 25 Nephelometric turbidity units by any point source discharge.

g. Cations and anions guideline values to protect livestock watering may be found in the “Supporting Document for Iowa Water Quality Management Plans,” Chapter IV, July 1976, as revised on November 11, 2009.

h. The *Escherichia coli* (*E. coli*) content of water which enters a sinkhole or losing stream segment, regardless of the water body’s designated use, shall not exceed a Geometric Mean value of 126 organisms/100 ml or a sample maximum value of 235 organisms/100 ml. No new wastewater discharges will be allowed on watercourses which directly or indirectly enter sinkholes or losing stream segments.

61.3(3) Specific water quality criteria.

a. *Class “A” waters.* Waters which are designated as Class “A1,” “A2,” or “A3” in subrule 61.3(5) are to be protected for primary contact, secondary contact, and children’s recreational uses. The general criteria of subrule 61.3(2) and the following specific criteria apply to all Class “A” waters.

(1) The *Escherichia coli* (*E. coli*) content shall not exceed the levels noted in the Bacteria Criteria Table when the Class “A1,” “A2,” or “A3” uses can reasonably be expected to occur.

Bacteria Criteria Table (organisms/100 ml of water)

Use or Category	Geometric Mean	Sample Maximum
Class A1		
3/15 – 11/15	126	235
11/16 – 3/14	Does not apply	Does not apply
Class A2 (Only)		
3/15 – 11/15	630	2880
11/16 – 3/14	Does not apply	Does not apply
[Class A2 and B(CW)] or OIW or ONRW		
Year-Round	630	2880
Class A3		
3/15 – 11/15	126	235
11/16 – 3/14	Does not apply	Does not apply
Class A1 - Primary Contact Recreational Use Class A2 - Secondary Contact Recreational Use Class A3 - Children’s Recreational Use		

When a water body is designated for more than one of the recreational uses, the most stringent criteria for the appropriate season shall apply.

(2) The pH shall not be less than 6.5 nor greater than 9.0. The maximum change permitted as a result of a waste discharge shall not exceed 0.5 pH units.

b. *Class “B” waters.* All waters which are designated as Class B(CW1), B(CW2), B(WW-1), B(WW-2), B(WW-3) or B(LW) are to be protected for wildlife, fish, aquatic, and semiaquatic life. The following criteria shall apply to all Class “B” waters designated in subrule 61.3(5).

(1) Dissolved oxygen. Dissolved oxygen shall not be less than the values shown in Table 2 of this subrule.

(2) pH. The pH shall not be less than 6.5 nor greater than 9.0. The maximum change permitted as a result of a waste discharge shall not exceed 0.5 pH units.

(3) General chemical constituents. The specific numerical criteria shown in Tables 1, 2, and 3 of this subrule apply to all waters designated in subrule 61.3(5). The sole determinant of compliance

with these criteria will be established by the department on a case-by-case basis. Effluent monitoring or instream monitoring, or both, will be the required approach to determine compliance.

1. The acute criteria represent the level of protection necessary to prevent acute toxicity to aquatic life. Instream concentrations above the acute criteria will be allowed only within the boundaries of the zone of initial dilution.

2. The chronic criteria represent the level of protection necessary to prevent chronic toxicity to aquatic life. Excursions above the chronic criteria will be allowed only inside of mixing zones or only for short-term periods outside of mixing zones; however, these excursions cannot exceed the acute criteria shown in Tables 1 and 3. The chronic criteria will be met as short-term average conditions at all times the flow equals or exceeds either the design flows noted in subrule 61.2(5) or any site-specific low flow established under the provisions of subrule 61.2(5).

3. Rescinded IAB 2/15/06, effective 3/22/06.

(4) Rescinded IAB 2/15/06, effective 3/22/06.

(5) Temperature.

1. No heat shall be added to interior streams or the Big Sioux River that would cause an increase of more than 3°C. The rate of temperature change shall not exceed 1°C per hour. In no case shall heat be added in excess of that amount that would raise the stream temperature above 32°C.

2. No heat shall be added to streams designated as cold water fisheries that would cause an increase of more than 2°C. The rate of temperature change shall not exceed 1°C per hour. In no case shall heat be added in excess of that amount that would raise the stream temperature above 20°C.

3. No heat shall be added to lakes and reservoirs that would cause an increase of more than 2°C. The rate of temperature change shall not exceed 1°C per hour. In no case shall heat be added in excess of that amount that would raise the temperature of the lake or reservoirs above 32°C.

4. No heat shall be added to the Missouri River that would cause an increase of more than 3°C. The rate of temperature change shall not exceed 1°C per hour. In no case shall heat be added that would raise the stream temperature above 32°C.

5. No heat shall be added to the Mississippi River that would cause an increase of more than 3°C. The rate of temperature change shall not exceed 1°C per hour. In addition, the water temperature at representative locations in the Mississippi River shall not exceed the maximum limits in the table below during more than 1 percent of the hours in the 12-month period ending with any month. Moreover, at no time shall the water temperature at such locations exceed the maximum limits in the table below by more than 2°C.

Zone II—Iowa-Minnesota state line to the northern Illinois border (Mile Point 1534.6).

Zone III—Northern Illinois border (Mile Point 1534.6) to Iowa-Missouri state line.

Month	Zone II	Zone III
January	4°C	7°C
February	4°C	7°C
March	12°C	14°C
April	18°C	20°C
May	24°C	26°C
June	29°C	29°C
July	29°C	30°C
August	29°C	30°C
September	28°C	29°C
October	23°C	24°C
November	14°C	18°C
December	9°C	11°C

(6) Early life stage for each use designation. The following seasons will be used in applying the early life stage present chronic criteria noted in Table 3b, "Chronic Criterion for Ammonia in Iowa Streams - Early Life Stages Present."

1. For all Class B(CW1) waters, the early life stage will be year-round.
2. For all Class B(CW2) waters, the early life stage will begin on April 1 and last through September 30.
3. For all Class B(WW-1) waters, the early life stage will begin in March and last through September, except as follows:
 - For the following, the early life stage will begin in February and last through September:
 - The entire length of the Mississippi and Missouri Rivers,
 - The lower reach of the Des Moines River south of the Ottumwa dam, and
 - The lower reach of the Iowa River below the Cedar River.
 - For the following, the early life stage will begin in April and last through September:
 - All Class B(WW-1) waters in the Southern Iowa River Basin,
 - All of the Class B(WW-1) reach of the Skunk River, the North Skunk River and the South Skunk River south of Indian Creek (Jasper County), and the Class B(WW-1) tributaries to these reaches, and the entire Class B(WW-1) reach of the English River.
4. For all Class B(WW-2) and Class B(WW-3) waters, the early life stage will begin in April and last through September.
5. For all Class B(LW) lake and wetland waters, the early life stage will begin in March and last through September except for the Class B(LW) waters in the southern two tiers of Iowa counties which will have the early life stage of April through September.

c. *Class "C" waters.* Waters which are designated as Class "C" are to be protected as a raw water source of potable water supply. The following criteria shall apply to all Class "C" waters designated in subrule 61.3(5).

- (1) Radioactive substances.
 1. The combined radium-226 and radium-228 shall not exceed 5 picocuries per liter at the point of withdrawal.
 2. Gross alpha particle activity (including radium-226 but excluding radon and uranium) shall not exceed 15 picocuries per liter at the point of withdrawal.
 3. The average annual concentration at the point of withdrawal of beta particle and photon radioactivity from man-made radionuclides other than tritium and strontium-90 shall not produce an annual dose equivalent to the total body or any internal organ greater than 4 millirem/year.
 4. The average annual concentration of tritium shall not exceed 20,000 picocuries per liter at the point of withdrawal; the average annual concentration of strontium-90 shall not exceed 8 picocuries per liter at the point of withdrawal.
- (2) All substances toxic or detrimental to humans or detrimental to treatment process shall be limited to nontoxic or nondetrimental concentrations in the surface water.
- (3) The pH shall not be less than 6.5 nor greater than 9.0.

d. *Class "HH" waters.* Waters which are designated as Class HH shall contain no substances in concentrations which will make fish or shellfish inedible due to undesirable tastes or cause a hazard to humans after consumption.

(1) The human health criteria represent the level of protection necessary, in the case of noncarcinogens, to prevent adverse health effects in humans and, in the case of carcinogens, to prevent a level of incremental cancer risk not exceeding 1 in 100,000. Instream concentrations in excess of the human health criteria will be allowed only within the boundaries of the mixing zone.

(2) Reserved.

TABLE 1. Criteria for Chemical Constituents

(all values as micrograms per liter as total recoverable unless noted otherwise)

Human health criteria for carcinogenic parameters noted below were based on the prevention of an incremental cancer risk of 1 in 100,000. For parameters not having a noted human health criterion, the U.S. Environmental Protection Agency has not developed final national human health guideline values.

Parameter		Use Designations						
		B(CW1)	B(CW2)	B(WW-1)	B(WW-2)	B(WW-3)	B(LW)	C HH
Chlordane	Chronic	.004	—	.0043	.0043	.0043	.004	—
	Acute	2.5	—	2.4	2.4	2.4	2.5	—
	Human Health — Fish	—	—	—	—	—	—	.0081 ^(e)
	Human Health — F & W	—	—	—	—	—	—	.008 ^(f)
Chloride	Chronic	389(m)*	389(m)*	389(m)*	389(m)*	389(m)*	389(m)*	—
	Acute	629(m)*	629(m)*	629(m)*	629(m)*	629(m)*	629(m)*	—
	MCL	—	—	—	—	—	—	250*
Chlorobenzene	Human Health + — Fish	—	—	—	—	—	—	1.6*(e)
	Human Health + — F & W	—	—	—	—	—	—	130 ^(f)
	MCL	—	—	—	—	—	—	100
Chlorodibromomethane	Human Health — F & W	—	—	—	—	—	—	4.0 ^(f)
	Human Health — Fish	—	—	—	—	—	—	130 ^(e)
Chloroform	Human Health — F & W	—	—	—	—	—	—	57 ^(f)
	Human Health — Fish	—	—	—	—	—	—	4700 ^(e)
Chloropyrifos	Chronic	.041	—	.041	.041	.041	.041	—
	Acute	.083	—	.083	.083	.083	.083	—
Chromium (VI)	Chronic	40	—	11	11	11	10	—
	Acute	60	—	16	16	16	15	—
	Human Health + — Fish	—	—	—	—	—	—	3365 ^(e)
	MCL	—	—	—	—	—	—	100
Copper	Chronic	20	—	16.9 ⁽ⁱ⁾	16.9 ⁽ⁱ⁾	16.9 ⁽ⁱ⁾	10	—
	Acute	30	—	26.9 ⁽ⁱ⁾	26.9 ⁽ⁱ⁾	26.9 ⁽ⁱ⁾	20	—
	Human Health + — Fish	—	—	—	—	—	—	1000 ^(e)
	Human Health + — F & W	—	—	—	—	—	—	1300 ^(f)
Cyanide	Chronic	5	—	5.2	5.2	5.2	10	—
	Acute	20	—	22	22	22	45	—
	Human Health + — F & W	—	—	—	—	—	—	140 ^(f)
	Human Health — Fish	—	—	—	—	—	—	140 ^(e)
Dalapon	MCL	—	—	—	—	—	—	200
Dibromochloropropane	MCL	—	—	—	—	—	—	.2
4,4-DDT ++	Chronic	.001	—	.001	.001	.001	.001	—
	Acute	.9	—	1.1	1.1	1.1	.55	—
	Human Health — Fish	—	—	—	—	—	—	.0022 ^(e)
	Human Health — F & W	—	—	—	—	—	—	.0022 ^(f)
o-Dichlorobenzene	MCL	—	—	—	—	—	—	600

[illegible]

Parameter		Use Designations						C	HH
		B(CW1)	B(CW2)	B(WW-1)	B(WW-2)	B(WW-3)	B(LW)		
Nitrate as N	MCL	—	—	—	—	—	—	10*	—
Nitrate + Nitrite as N	MCL	—	—	—	—	—	—	10*	—
Nitrite as N	MCL	—	—	—	—	—	—	1*	—
Oxamyl (Vydate)	MCL	—	—	—	—	—	—	200	—
Parathion	Chronic	.013	—	.013	.013	.013	.013	—	—
	Acute	.065	—	.065	.065	.065	.065	—	—
Pentachlorophenol (PCP)	Chronic	(d)	—	(d)	(d)	(d)	(d)	—	—
	Acute	(d)	—	(d)	(d)	(d)	(d)	—	—
	Human Health — Fish	—	—	—	—	—	—	—	30(e)
	Human Health — F & W	—	—	—	—	—	—	—	2.7(f)
Phenols	Chronic	50	—	50	50	50	50	—	—
	Acute	1000	—	2500	2500	2500	1000	—	—
	Human Health + — Fish	—	—	—	—	—	—	—	1700*(e)
	Human Health + — F & W	—	—	—	—	—	—	—	21*(f)
Picloram	MCL	—	—	—	—	—	—	500	—
Polychlorinated Biphenyls (PCBs)	Chronic	.014	—	.014	.014	.014	.014	—	—
	Acute	2	—	2	2	2	2	—	—
	Human Health — Fish	—	—	—	—	—	—	—	.00064(e)
	Human Health — F & W	—	—	—	—	—	—	—	.00064(f)
Polynuclear Aromatic Hydrocarbons (PAHs)**	Chronic	.03	—	.03	3	3	.03	—	—
	Acute	30	—	30	30	30	30	—	—
	Human Health — Fish	—	—	—	—	—	—	—	.18(e)
	Human Health — F & W	—	—	—	—	—	—	—	.038(f)
Selenium	Chronic	10	—	5	5	5	70	—	—
	Acute	15	—	19.3	19.3	19.3	100	—	—
	Human Health + — F & W	—	—	—	—	—	—	—	170(f)
	Human Health + — Fish	—	—	—	—	—	—	—	4200(e)
Silver	Chronic	N/A	—	N/A	N/A	N/A	N/A	—	—
	Acute	30	—	3.8	3.8	3.8	4	—	—
	MCL	—	—	—	—	—	—	50	—
2,4,5-TP (Silvex)	MCL	—	—	—	—	—	—	10	—
Simazine	MCL	—	—	—	—	—	—	4	—
Styrene	MCL	—	—	—	—	—	—	100	—

* units expressed as milligrams/liter

** to include the sum of known and suspected carcinogenic PAHs (includes benzo(a)anthracene, benzo(b)fluoranthene, benzo(k)fluoranthene, chrysene, dibenzo(a,h)anthracene, and indeno(1,2,3-cd)pyrene)

† expressed as nanograms/liter

+ represents the noncarcinogenic human health parameters

++ The concentrations of 4,4-DDT or its metabolites; 4,4-DDE and 4,4-DDD, individually shall not exceed the human health criteria.

(a) units expressed as million fibers/liter (longer than 10 micrometers)

(b) includes alpha-endosulfan, beta-endosulfan, and endosulfan sulfate in combination or as individually measured

(c) The sum of the four trihalomethanes (bromoform [tribromomethane], chlorodibromomethane, chloroform [trichloromethane], and dichlorobromomethane) may not exceed the MCL.

(d) Class B numerical criteria for pentachlorophenol are a function of pH using the equation: Criterion ($\mu\text{g/l}$) = $e^{[1.005(\text{pH}) - x]}$, where $e = 2.71828$ and x varies according to the following table:

	B(CW1)	B(CW2)	B(WW-1)	B(WW-2)	B(WW-3)	B(LW)
Acute	3.869	—	4.869	4.869	4.869	4.869
Chronic	4.134	—	5.134	5.134	5.134	5.134

(e) This Class HH criterion would be applicable to any Class B(LW), B(CW1), B(WW-1), B(WW-2), or B(WW-3) water body that is also designated Class HH.

(f) This Class HH criterion would be applicable to any Class C water body that is also designated Class HH.

(g) inorganic form only

(h) Class B(WW-1), B(WW-2), and B(WW-3) criteria listed in main table are based on a hardness of 200 mg/l (as CaCO_3 (mg/l)). Numerical criteria ($\mu\text{g/l}$) for cadmium are a function of hardness (as CaCO_3 (mg/l)) using the equation for each use according to the following table:

	B(WW-1)	B(WW-2)	B(WW-3)
Acute	$e^{[1.0166\text{Ln}(\text{Hardness}) - 3.924]}$	$e^{[1.0166\text{Ln}(\text{Hardness}) - 3.924]}$	$e^{[1.0166\text{Ln}(\text{Hardness}) - 3.924]}$
Chronic	$e^{[0.7409\text{Ln}(\text{Hardness}) - 4.719]}$	$e^{[0.7409\text{Ln}(\text{Hardness}) - 4.719]}$	$e^{[0.7409\text{Ln}(\text{Hardness}) - 4.719]}$

(i) Class B(WW-1), B(WW-2), and B(WW-3) criteria listed in main table are based on a hardness of 200 mg/l (as CaCO_3 (mg/l)). Numerical criteria ($\mu\text{g/l}$) for copper are a function of hardness (CaCO_3 (mg/l)) using the equation for each use according to the following table:

	B(WW-1)	B(WW-2)	B(WW-3)
Acute	$e^{[0.9422\text{Ln}(\text{Hardness}) - 1.700]}$	$e^{[0.9422\text{Ln}(\text{Hardness}) - 1.700]}$	$e^{[0.9422\text{Ln}(\text{Hardness}) - 1.700]}$
Chronic	$e^{[0.8545\text{Ln}(\text{Hardness}) - 1.702]}$	$e^{[0.8545\text{Ln}(\text{Hardness}) - 1.702]}$	$e^{[0.8545\text{Ln}(\text{Hardness}) - 1.702]}$

(j) Class B(WW-1), B(WW-2), and B(WW-3) criteria listed in main table are based on a hardness of 200 mg/l (as CaCO_3 (mg/l)). Numerical criteria ($\mu\text{g/l}$) for lead are a function of hardness (CaCO_3 (mg/l)) using the equation for each use according to the following table:

	B(WW-1)	B(WW-2)	B(WW-3)
Acute	$e^{[1.2731\text{Ln}(\text{Hardness}) - 1.46]}$	$e^{[1.2731\text{Ln}(\text{Hardness}) - 1.46]}$	$e^{[1.2731\text{Ln}(\text{Hardness}) - 1.46]}$
Chronic	$e^{[1.2731\text{Ln}(\text{Hardness}) - 4.705]}$	$e^{[1.2731\text{Ln}(\text{Hardness}) - 4.705]}$	$e^{[1.2731\text{Ln}(\text{Hardness}) - 4.705]}$

(k) Class B(WW-1), B(WW-2), and B(WW-3) criteria listed in main table are based on a hardness of 200 mg/l (as CaCO_3 (mg/l)). Numerical criteria ($\mu\text{g/l}$) for nickel are a function of hardness (CaCO_3 (mg/l)) using the equation for each use according to the following table:

	B(WW-1)	B(WW-2)	B(WW-3)
Acute	$e^{[0.846\text{Ln}(\text{Hardness}) + 2.255]}$	$e^{[0.846\text{Ln}(\text{Hardness}) + 2.255]}$	$e^{[0.846\text{Ln}(\text{Hardness}) + 2.255]}$
Chronic	$e^{[0.846\text{Ln}(\text{Hardness}) + 0.0584]}$	$e^{[0.846\text{Ln}(\text{Hardness}) + 0.0584]}$	$e^{[0.846\text{Ln}(\text{Hardness}) + 0.0584]}$

(l) Class B(WW-1), B(WW-2), and B(WW-3) criteria listed in main table are based on a hardness of 200 mg/l (as CaCO_3 (mg/l)). Numerical criteria ($\mu\text{g/l}$) for zinc are a function of hardness (CaCO_3 (mg/l)) using the equation for each use according to the following table:

	B(WW-1)	B(WW-2)	B(WW-3)
Acute	$e^{[0.8473\text{Ln(Hardness)} + 0.884]}$	$e^{[0.8473\text{Ln(Hardness)} + 0.884]}$	$e^{[0.8473\text{Ln(Hardness)} + 0.884]}$
Chronic	$e^{[0.8473\text{Ln(Hardness)} + 0.884]}$	$e^{[0.8473\text{Ln(Hardness)} + 0.884]}$	$e^{[0.8473\text{Ln(Hardness)} + 0.884]}$

- (m) Acute and chronic criteria listed in main table are based on a hardness of 200 mg/l (as CaCO₃ (mg/l)) and a sulfate concentration of 63 mg/l. Numerical criteria (µg/l) for chloride are a function of hardness (CaCO₃ (mg/l)) and sulfate (mg/l) using the equation for each use according to the following table:

	B(CW1), B(CW2), B(WW-1), B(WW-2), B(WW-3), B(LW)
Acute	$287.8(\text{Hardness})^{0.205797}(\text{Sulfate})^{-0.07452}$
Chronic	$177.87(\text{Hardness})^{0.205797}(\text{Sulfate})^{-0.07452}$

TABLE 2. Criteria for Dissolved Oxygen

(all values expressed in milligrams per liter)

	B(CW1)	B(CW2)	B(WW-1)	B(WW-2)	B(WW-3)	B(LW)
Minimum value for at least 16 hours of every 24-hour period	7.0	7.0	5.0	5.0	5.0	5.0*
Minimum value at any time during every 24-hour period	5.0	5.0	5.0	4.0	4.0	5.0*

**applies only to the upper layer of stratification in lakes*

TABLE 3a. Acute Criterion for Ammonia in Iowa Streams

Acute Criterion, mg/l as N (or Criterion Maximum Concentration, CMC)		
pH	Class B(WW-1), B(WW-2), B(WW-3) & B(LW)	Class B(CW1) & B(CW2)
6.5	48.8	32.6
6.6	46.8	31.3
6.7	44.6	29.8
6.8	42.0	28.0
6.9	39.1	26.1
7.0	36.1	24.1
7.1	32.8	21.9
7.2	29.5	19.7
7.3	26.2	17.5
7.4	23.0	15.3
7.5	19.9	13.3
7.6	17.0	11.4
7.7	14.4	9.64
7.8	12.1	8.11
7.9	10.1	6.77
8.0	8.40	5.62
8.1	6.95	4.64
8.2	5.72	3.83
8.3	4.71	3.15
8.4	3.88	2.59

Acute Criterion, mg/l as N (or Criterion Maximum Concentration, CMC)		
pH	Class B(WW-1), B(WW-2), B(WW-3) & B(LW)	Class B(CW1) & B(CW2)
8.5	3.20	2.14
8.6	2.65	1.77
8.7	2.20	1.47
8.8	1.84	1.23
8.9	1.56	1.04
9.0	1.32	0.885

TABLE 3b. Chronic Criterion for Ammonia in Iowa Streams - Early Life Stages Present

Chronic Criterion - Early Life Stages Present, mg/l as N (or Criterion Continuous Concentration, CCC)										
pH	Temperature, °C									
	0	14	16	18	20	22	24	26	28	30
6.5	6.67	6.67	6.06	5.33	4.68	4.12	3.62	3.18	2.80	2.46
6.6	6.57	6.57	5.97	5.25	4.61	4.05	3.56	3.13	2.75	2.42
6.7	6.44	6.44	5.86	5.15	4.52	3.98	3.50	3.07	2.70	2.37
6.8	6.29	6.29	5.72	5.03	4.42	3.89	3.42	3.00	2.64	2.32
6.9	6.12	6.12	5.56	4.89	4.30	3.78	3.32	2.92	2.57	2.25
7.0	5.91	5.91	5.37	4.72	4.15	3.65	3.21	2.82	2.48	2.18
7.1	5.67	5.67	5.15	4.53	3.98	3.50	3.08	2.70	2.38	2.09
7.2	5.39	5.39	4.90	4.31	3.78	3.33	2.92	2.57	2.26	1.99
7.3	5.08	5.08	4.61	4.06	3.57	3.13	2.76	2.42	2.13	1.87
7.4	4.73	4.73	4.30	3.78	3.32	2.92	2.57	2.26	1.98	1.74
7.5	4.36	4.36	3.97	3.49	3.06	2.69	2.37	2.08	1.83	1.61
7.6	3.98	3.98	3.61	3.18	2.79	2.45	2.16	1.90	1.67	1.47
7.7	3.58	3.58	3.25	2.86	2.51	2.21	1.94	1.71	1.50	1.32
7.8	3.18	3.18	2.89	2.54	2.23	1.96	1.73	1.52	1.33	1.17
7.9	2.8	2.8	2.54	2.24	1.96	1.73	1.52	1.33	1.17	1.03
8.0	2.43	2.43	2.21	1.94	1.71	1.50	1.32	1.16	1.02	0.897
8.1	2.10	2.10	1.91	1.68	1.47	1.29	1.14	1.00	0.879	0.773
8.2	1.79	1.79	1.63	1.43	1.26	1.11	0.973	0.855	0.752	0.661
8.3	1.52	1.52	1.39	1.22	1.07	0.941	0.827	0.727	0.639	0.562
8.4	1.29	1.29	1.17	1.03	0.906	0.796	0.700	0.615	0.541	0.475
8.5	1.09	1.09	0.990	0.870	0.765	0.672	0.591	0.520	0.457	0.401
8.6	0.920	0.920	0.836	0.735	0.646	0.568	0.499	0.439	0.386	0.339
8.7	0.778	0.778	0.707	0.622	0.547	0.480	0.422	0.371	0.326	0.287
8.8	0.661	0.661	0.601	0.528	0.464	0.408	0.359	0.315	0.277	0.244
8.9	0.565	0.565	0.513	0.451	0.397	0.349	0.306	0.269	0.237	0.208
9.0	0.486	0.486	0.442	0.389	0.342	0.300	0.264	0.232	0.204	0.179

TABLE 3c. Chronic Criterion for Ammonia in Iowa Streams - Early Life Stages Absent

Chronic Criterion - Early Life Stages Absent, mg/l as N (or Criterion Continuous Concentration, CCC)										
pH	Temperature, °C									
	0-7	8	9	10	11	12	13	14	15*	16*
6.5	10.8	10.1	9.51	8.92	8.36	7.84	7.35	6.89	6.46	6.06
6.6	10.7	9.99	9.37	8.79	8.24	7.72	7.24	6.79	6.36	5.97
6.7	10.5	9.81	9.20	8.62	8.08	7.58	7.11	6.66	6.25	5.86
6.8	10.2	9.58	8.98	8.42	7.90	7.40	6.94	6.51	6.10	5.72
6.9	9.93	9.31	8.73	8.19	7.68	7.20	6.75	6.33	5.93	5.56
7.0	9.60	9.00	8.43	7.91	7.41	6.95	6.52	6.11	5.73	5.37
7.1	9.20	8.63	8.09	7.58	7.11	6.67	6.25	5.86	5.49	5.15
7.2	8.75	8.20	7.69	7.21	6.76	6.34	5.94	5.57	5.22	4.90
7.3	8.24	7.73	7.25	6.79	6.37	5.97	5.60	5.25	4.92	4.61
7.4	7.69	7.21	6.76	6.33	5.94	5.57	5.22	4.89	4.59	4.30
7.5	7.09	6.64	6.23	5.84	5.48	5.13	4.81	4.51	4.23	3.97
7.6	6.46	6.05	5.67	5.32	4.99	4.68	4.38	4.11	3.85	3.61
7.7	5.81	5.45	5.11	4.79	4.49	4.21	3.95	3.70	3.47	3.25
7.8	5.17	4.84	4.54	4.26	3.99	3.74	3.51	3.29	3.09	2.89
7.9	4.54	4.26	3.99	3.74	3.51	3.29	3.09	2.89	2.71	2.54
8.0	3.95	3.70	3.47	3.26	3.05	2.86	2.68	2.52	2.36	2.21
8.1	3.41	3.19	2.99	2.81	2.63	2.47	2.31	2.17	2.03	1.91
8.2	2.91	2.73	2.56	2.40	2.25	2.11	1.98	1.85	1.74	1.63
8.3	2.47	2.32	2.18	2.04	1.91	1.79	1.68	1.58	1.48	1.39
8.4	2.09	1.96	1.84	1.73	1.62	1.52	1.42	1.33	1.25	1.17
8.5	1.77	1.66	1.55	1.46	1.37	1.28	1.20	1.13	1.06	0.99
8.6	1.49	1.40	1.31	1.23	1.15	1.08	1.01	0.951	0.892	0.836
8.7	1.26	1.18	1.11	1.04	0.976	0.915	0.858	0.805	0.754	0.707
8.8	1.07	1.01	0.944	0.885	0.829	0.778	0.729	0.684	0.641	0.601
8.9	0.917	0.860	0.806	0.756	0.709	0.664	0.623	0.584	0.548	0.513
9.0	0.790	0.740	0.694	0.651	0.610	0.572	0.536	0.503	0.471	0.442

*At 15°C and above, the criterion for fish early life stage (ELS) absent is the same as the criterion for fish ELS present.

TABLE 4. Aquatic Life Criteria for Sulfate for Class B Waters

(all values expressed in milligrams per liter)

Hardness mg/l as CaCO ₃	Chloride		
	Cl ⁻ < 5 mg/l	5 ≤ Cl ⁻ < 25	25 ≤ Cl ⁻ ≤ 500
H < 100 mg/l	500	500	500
100 ≤ H ≤ 500	500	$[-57.478 + 5.79(\text{hardness}) + 54.163(\text{chloride})] \times 0.65$	$[1276.7 + 5.508(\text{hardness}) - 1.457(\text{chloride})] \times 0.65$
H > 500	500	2,000	2,000

61.3(4) Class “C” waters. Rescinded IAB 4/18/90, effective 5/23/90.

61.3(5) Surface water classification. The department hereby incorporates by reference “Surface Water Classification,” effective December 22, 2010. This document may be obtained on the department’s Web site at <http://www.iowadnr.com/water/standards/index.html>.

61.3(6) *Cold water use designation assessment protocol.* The department hereby incorporates by reference “Cold Water Use Designation Assessment Protocol,” effective December 15, 2004. This document may be obtained on the department’s Web site at <http://www.iowadnr.com/water/standards/index.html>.

61.3(7) *Warm water stream use assessment and attainability analysis protocol.* The department hereby incorporates by reference “Warm Water Stream Use Assessment and Attainability Analysis Protocol,” effective March 22, 2006. This document may be obtained on the departments Web site at <http://www.iowadnr.com/water/standards/index.html>.

61.3(8) *Recreational use assessment and attainability analysis protocol.* The department hereby incorporates by reference “Recreational Use Assessment and Attainability Analysis Protocol,” effective March 19, 2008. This document may be obtained on the department’s Web site.

This rule is intended to implement Iowa Code chapter 455B, division I, and division III, part 1. [ARC 8039B, IAB 8/12/09, effective 9/16/09; ARC 8214B, IAB 10/7/09, effective 11/11/09; ARC 8226B, IAB 10/7/09, effective 11/11/09; ARC 8466B, IAB 1/13/10, effective 2/17/10; ARC 9223B, IAB 11/17/10, effective 12/22/10]

567—61.4 to 61.9 Reserved.

VOLUNTEER MONITORING DATA REQUIREMENTS

567—61.10(455B) Purpose. The department uses water quality monitoring data for a number of purposes, including determining compliance with effluent limits for operation permits issued under 567—Chapter 64. The department also uses water quality monitoring data to determine the relative health of a water body by comparing monitoring data to the appropriate water quality standards established in 567—Chapter 61, a process known as water body assessments. Water body assessments are performed to prepare the biennial water quality report required under Section 305(b) of the Act and the list of impaired waters under Section 303(d) of the Act.

Iowa Code sections 455B.193 to 455B.195 require that credible data, as defined in Iowa Code section 455B.171, be used for the purpose of preparing Section 303(d) lists and other water quality program functions. Data provided by a volunteer are not considered credible data unless provided by a qualified volunteer. The purpose of this chapter is to establish minimum requirements for data produced by volunteers to meet the credible data and qualified volunteer requirements.

567—61.11(455B) Monitoring plan required. Volunteer water quality monitoring data submitted to the department must have been produced in accordance with a department-approved volunteer water quality monitoring plan before the data may be used for any of the purposes listed in Iowa Code section 455B.194. Approval of a plan will establish qualified volunteer status for the personnel identified in the plan for those monitoring activities covered under the plan.

61.11(1) Submittal of the plan. Prior to initiation of volunteer water quality monitoring activities intended to produce credible data, a water quality monitoring plan must be submitted to the department for review and approval. The plan must be submitted to the Volunteer Monitoring Coordinator, Department of Natural Resources, Wallace State Office Building, Des Moines, Iowa 50319, a minimum of 90 days before planned initiation of volunteer monitoring activities. A letter transmitting the plan must specifically request formal review and approval of the plan and identify a contact person. Volunteer monitors are encouraged to communicate with the department and to attend volunteer monitoring training sessions prior to formal submittal of a plan.

61.11(2) Content of the plan. A volunteer monitoring plan must contain, at a minimum, the following to be considered an acceptable volunteer monitoring plan:

- a. A statement of the intent of the monitoring effort.
- b. The name(s) of the person or persons that will be involved in data collection or analysis, the specific responsibilities of each person or group of people, and the general qualifications of the volunteers to carry out those responsibilities. For groups, such as educational institutions, it will be acceptable to identify the persons involved by general description (e.g., tenth grade biology class) with the exception of persons in responsible charge.

c. The name(s) of the person or persons that will oversee the monitoring plan, ensure that quality assurance and control objectives are being met, and certify the data. The person or persons in responsible charge must have training commensurate with the level of expertise to ensure that credible data is being generated.

d. The duration of the volunteer monitoring effort. In general, the department will not approve plans of greater than three years' duration unless a longer duration is justified.

e. Location and frequency of sample collection.

f. Methods of data collection and analysis.

g. Record keeping and data reporting procedures.

61.11(3) *Department review of the plan.* The department will review monitoring plans and normally approve or disapprove the plan within 90 days of receipt. The department will work with the contact person identified in the plan to make any necessary changes prior to taking formal action. The department will use guidelines contained in the publications EPA Requirements for Quality Assurance Project Plans (EPA QA/R-5, 2001) and Volunteer Monitor's Guide to Quality Assurance Project Plans (1966, EPA 841-B-96-003) or equivalent updates to determine if the plans provide adequate quality assurance and quality control measures. Approval or disapproval of the plan will be in the form of a letter and approval may include conditions or limitations.

61.11(4) *Changes in monitoring plans.* The department must approve any changes to an approved monitoring plan. Data collected under a modified plan will not be considered credible data until such time as the department has approved the modifications. Modifications to an approved plan should be submitted at the earliest possible time to avoid interruptions in data collection and to ensure continuity of data.

61.11(5) *Appeal of disapproval.* If a monitoring plan submitted for approval is disapproved, the decision may be appealed by filing an appeal with the director within 30 days of disapproval. The form of the notice of appeal and appeal procedures are governed by 567—Chapter 7.

567—61.12(455B) Use of volunteer monitoring data. Data produced under an approved water quality monitoring plan will be considered credible data for the purposes listed in Iowa Code section 455B.194 if the following conditions are met.

61.12(1) *Data submittal.* A qualified volunteer monitor or qualified volunteer monitoring group must specifically request that data produced under an approved volunteer monitoring plan be considered credible data. A letter identifying the specific data must be submitted along with a certification from the volunteer or the person in responsible charge for volunteer groups that the data, to the best of the volunteer's or responsible person's knowledge, was produced in accordance with the approved volunteer monitoring plan. The department shall provide a standard format on the IOWATER Web site for submittal of qualified volunteer data and related information. The department encourages volunteers to enter monitoring data on the IOWATER volunteer monitoring database maintained by the department, but doing so does not constitute submittal to or acceptance of the data by the department for uses requiring credible data. Volunteer data shall be labeled as such in any departmental reports, Web sites, or databases.

61.12(2) *Department review of submitted data.* The department must review and approve the submitted data. The person submitting the data will be informed of the department's decision either to accept or reject the data. The department will attempt to resolve any apparent inconsistencies or questionable values in the submitted data prior to making a final decision.

567—61.13(455B) Department audits of volunteer monitoring activities. The department shall conduct field audits of a statistically valid and representative sample of volunteer data collection and analysis procedures to ensure compliance with an approved plan and may conduct confirmatory monitoring tests. Volunteers shall be informed of any audit results and be provided with an opportunity to address any concerns to the extent possible. The department reserves the right to rescind approval of

an approved plan if it finds substantial problems that cannot be addressed in a timely manner to ensure the quality of the data being produced.

These rules are intended to implement Iowa Code chapter 455B, division III, part 1.

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CHAPTER 502
ELECTRICIAN AND ELECTRICAL CONTRACTOR LICENSING PROGRAM—LICENSING
REQUIREMENTS, PROCEDURES, AND FEES

661—502.1(103) License categories and licenses required.

502.1(1) The following license categories are established:

- a.* Electrical contractor.
- b.* Residential electrical contractor.
- c.* Master electrician, class A.
- d.* Master electrician, class B.
- e.* Residential master electrician.
- f.* Journeyman electrician, class A.
- g.* Journeyman electrician, class B.
- h.* Residential electrician.
- i.* Apprentice electrician.
- j.* Special electrician.
- k.* Unclassified person.
- l.* Inactive master electrician.

502.1(2) A person who holds any class of license issued by the board, other than a class B license, a residential electrical contractor license, a residential master electrician license, or a residential electrician license, may perform the work authorized by that license anywhere within the state of Iowa. A person who holds a special electrician license may perform the work which is authorized by that license endorsement. A person who holds a class B license may perform the work authorized by that license except in a political subdivision which, by local ordinance, has, pursuant to Iowa Code section 103.29, subsection 4, restricted or barred such work by a person who holds a class B license. A person who holds a residential electrical contractor license, a residential master electrician license, or a residential electrician license may perform the work authorized by that license anywhere within the state of Iowa except within a political subdivision which has, by local ordinance, restricted the use of such a license.

502.1(3) A person who does not have a current valid license shall not perform work as an electrician or as an unclassified person. A person shall not perform work which requires licensing and which is not specifically authorized under the license issued.

EXCEPTION 1: A person who holds a current valid license issued by a political subdivision may perform work as an electrician or unclassified person within the corporate limits of the political subdivision which issued the license.

EXCEPTION 2: A person may work for up to 100 continuous days as an unclassified person prior to obtaining a license. Any documented time during which a person has worked as an unclassified person prior to January 1, 2008, or any time during which a person has worked as a licensed unclassified person shall be credited to any applicable experience requirement. Any time during which a person works as an unclassified person without a license on or after January 1, 2008, shall not be counted toward any such experience requirement, except that a person may receive credit for time worked as an unclassified person on or after January 1, 2008, without a license if the person has applied for a license.

EXCEPTION 3: Electrical installations in buildings, including residences or facilities which are being constructed as part of a course of instruction by an accredited educational institution, may be performed by a person who is not licensed. Such installations are subject to the requirements for permits and inspections pursuant to 661—Chapter 552.

502.1(4) An apprentice electrician or an unclassified person, while performing electrical work, shall be directly supervised at all times by a master electrician or a journeyman electrician or, while performing residential electrical work only, by a residential master electrician, a residential electrician, or a special residential electrician. A master electrician, a journeyman electrician, a residential master electrician, a residential electrician, or a special residential electrician shall at no time directly supervise more than three apprentice electricians and unclassified persons at once. For purposes of this subrule, “unclassified

person” includes a person who is working as an unclassified person and holds either an “unclassified person” license or another license issued by the board.

502.1(5) A journeyman electrician or a residential electrician shall work under the general direction of a master electrician or, while performing residential electrical work only, under the general direction of a residential master electrician. A special residential electrician may perform residential work without supervision or direction.

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661—502.2(103) License requirements.

502.2(1) An electrical contractor license may be issued to a person who submits to the board the required application with the applicable fee, who holds or employs a person who holds an active master electrician license, who is registered as a contractor with the labor services division of Iowa workforce development, and who is not disqualified pursuant to rule 661—502.4(103). An electrical contractor license issued to a person who holds a class B master electrician license is subject to the same restriction of use as is the class B master electrician license.

502.2(2) A residential electrical contractor license may be issued to a person who is licensed as a class A master electrician, a class B master electrician, or a residential master electrician and who is registered with the state of Iowa as a contractor pursuant to Iowa Code chapter 91C.

502.2(3) A class A master electrician license may be issued to a person who submits to the board a completed application with the applicable fee, who is not disqualified from holding a license pursuant to rule 661—502.4(103), and who meets one of the following requirements:

a. Has completed one year of experience as a licensed journeyman electrician, and has passed a supervised written examination for master electrician approved by the board with a score of 75 or higher; or

b. As of December 31, 2007, held a current valid license as a master electrician issued by a political subdivision in Iowa, the issuance of which required passing a supervised written examination approved by the board, and one year of experience as a journeyman electrician; or

c. Holds a current class B master electrician license and has passed a supervised written examination for master electrician approved by the board with a score of 75 or higher.

502.2(4) A class B master electrician license may be issued to a person who submits to the board a completed application with the applicable fee; who is not disqualified from holding a license pursuant to rule 661—502.4(103); who presents credible evidence of having worked for a total of 16,000 hours of cumulative experience as a master electrician, of which at least 8,000 hours shall have been worked since January 1, 1998; and whose experience as a master electrician began on or before January 1, 1998.

502.2(5) A residential master electrician license may be issued to a person who submits to the board a completed application with the applicable fee, who is not disqualified from holding a license pursuant to rule 661—502.4(103), and who meets one of the following requirements:

a. Holds a current residential electrician or journeyman electrician license, has 2,000 hours of verified experience as a residential electrician or a journeyman electrician, and has passed a residential master electrician examination approved by the board; or

b. Holds a current special electrician license with a residential endorsement, has 4,000 hours of verified experience, and has passed a residential master electrician examination approved by the board.

502.2(6) A class A journeyman electrician license may be issued to a person who submits to the board a completed application with the applicable fee, who is not disqualified from holding a license pursuant to rule 661—502.4(103), and who meets one of the following requirements:

a. Has successfully completed a registered apprenticeship program, has passed a supervised written examination for journeyman electrician approved by the board with a score of 75 or higher, and has completed four years of experience as an apprentice electrician.

b. Holds a current class B journeyman electrician license and has passed a supervised written examination for journeyman electrician approved by the board with a score of 75 or higher.

c. Holds a current electrician license in another state, has passed a supervised written examination for journeyman electrician approved by the board with a score of 75 or higher, and has satisfied the sponsorship requirements for testing for a journeyman class A license by providing evidence of all of the following:

(1) Current licensure as a journeyman or master electrician from another state which required passing a test sponsored by that state.

(2) Completion of 18 hours of continuing education units approved by the board.

(3) Completion of 1,000 hours of work in Iowa as an unclassified person.

d. Holds a current license issued by the board, excluding a special electrician license other than special residential electrician license; has passed a supervised written examination for journeyman electrician approved by the board with a score of 75 or higher; has completed 54 hours of continuing education approved by the board; and has completed 16,000 hours of electrical work while licensed by the board, except as a special electrician other than a special residential electrician, as verified by a master electrician licensed by the board. The 16,000 hours must include at least the following minimum number of hours of work on commercial or industrial installations in the categories indicated: 500 hours of preliminary work, 2,000 hours of rough-in work, 2,000 hours of finish work, 2,000 hours of lighting and service work, 500 hours of troubleshooting, and 500 hours of motor control work. At least 4,000 hours of the 16,000 hours must have been completed by the applicant within the five years immediately preceding the submission date of the application.

EXCEPTION: On or before December 31, 2019, a maximum of 10,000 of the required 16,000 hours of verified work experience may have been completed between January 1, 2000, and December 31, 2007, without licensure from the board or from any political subdivision.

e. Holds a current license issued by the board as a residential electrician or residential master electrician, has passed a supervised written examination for journeyman electrician approved by the board with a score of 75 or higher, and has completed 4,000 hours of work on commercial or industrial electrical installations while licensed by the board, as verified by a master electrician licensed by the board. The 4,000 hours must include at least the following minimum numbers of hours in the categories indicated: 100 hours of preliminary work, 500 hours of rough-in work, 500 hours of finish work, 500 hours of lighting and service work, 100 hours of troubleshooting, and 100 hours of motor control work.

f. Holds a current license issued by the board, has satisfactorily completed an approved postsecondary electrical education program, has passed a supervised written examination for journeyman electrician approved by the board with a score of 75 or higher, and, subsequent to beginning the postsecondary electrical education program, has completed at least 6,000 hours of electrical work while licensed by the board, as verified by a master electrician licensed by the board.

502.2(7) A class B journeyman electrician license may be issued to a person who submits to the board a completed application with the applicable fee; who is not disqualified from holding a license pursuant to rule 661—502.4(103); who presents credible evidence of having worked for a total of 16,000 hours of cumulative experience as a journeyman electrician or master electrician, of which at least 8,000 hours shall have been worked since January 1, 1998; and whose experience as a journeyman electrician or master electrician began on or before January 1, 1998.

502.2(8) A residential electrician license may be issued to a person who submits to the board a completed application with the applicable fee, who is not disqualified from holding a license pursuant to rule 661—502.4(103), and who meets one of the following requirements:

a. Holds a current residential special electrician license and has held that license for a minimum of one year and has passed a residential electrician examination approved by the board; or

b. Has completed 6,000 hours of experience as an apprentice electrician and has passed a residential electrician examination approved by the board. An applicant may take the examination required by this paragraph after completing 5,000 hours of experience as an apprentice electrician, although the license will not be issued until the applicant has completed 6,000 hours of such experience; or

c. Has completed 4,000 hours of experience working under the direct supervision of a residential master electrician, a residential electrician, a master electrician, or a journeyman electrician; has

successfully completed a minimum of one academic year of an electrical trade school approved by the board; and has passed a residential electrician examination approved by the board; or

d. Has completed 8,000 hours of verified experience as a licensed unclassified person including at least 2,000 hours of verified work experience in residential wiring and has passed a residential electrician examination approved by the board; or

e. Has successfully completed a registered residential electrician apprenticeship program and passed a supervised written residential electrician examination approved by the board with a score of 75 or higher.

502.2(9) A special electrician license may be issued to a person who submits to the board a completed application with the applicable fee, who is not disqualified from holding a license pursuant to rule 661—502.4(103), and who meets the qualifications for any endorsement entered on the license. Each special electrician license shall carry one or more endorsements as specified in paragraphs “a” through “d.”

a. Endorsement 1, “Irrigation System Wiring,” shall be included on a special electrician license if the licensee requests it and has passed a supervised examination approved by the board or has completed two years, or 4,000 hours, of documented experience in the wiring of irrigation systems.

b. Endorsement 2, “Disconnecting and Reconnecting Existing Air Conditioning and Refrigeration Systems,” shall be included on a special electrician license if the licensee requests it and has passed a supervised examination approved by the board or has completed two years of documented experience in the disconnecting and reconnecting of existing air conditioning and refrigeration systems.

NOTE: An individual who holds any of the following licenses issued by the plumbing and mechanical systems board established pursuant to Iowa Code section 105.3 is not required to hold a license issued by the electrical examining board in order to perform disconnection and reconnection of existing air conditioning and refrigeration systems:

1. Master HVAC.
2. Journeyman HVAC.
3. Master refrigeration.
4. Journeyman refrigeration.

c. Endorsement 3, “Sign Installation,” shall be included on a special electrician license if the licensee requests that it be included. This endorsement does not authorize a licensee to connect power to a sign that has a voltage greater than 220V and an ampere rating greater than 20 amps. Initial installation or upgrading of the branch circuits supplying power to the sign shall be completed by a licensed master electrician or by a licensed journeyman electrician under the supervision of a master electrician.

d. Endorsement 4, “Residential Electrician,” shall be included on a special electrician license if the licensee requests it and has passed a supervised written examination approved by the board or has completed four years of documented experience performing residential electrical work. A political subdivision may, by enactment of an ordinance filed with the board prior to its effective date, require that a special electrician performing work authorized by this endorsement be supervised by a master electrician. Special electrician licenses with “residential electrician” endorsements shall not be issued after December 31, 2010. Renewals of special electrician licenses with “residential electrician” endorsements shall not be issued after December 31, 2013.

502.2(10) An apprentice electrician license may be issued to a person who submits a completed application to the board with the applicable fee, who is not disqualified pursuant to rule 661—502.4(103), and who is participating in a registered apprenticeship program. A person may hold an apprentice electrician license for no more than six years from the original date on which an apprentice electrician license is granted, except that a person may apply to the board for an exception to this limitation based upon a documented hardship. “Documented hardship” includes, but is not limited to, an interruption in service as an apprentice electrician for active military duty or for an extended illness.

502.2(11) A license as an unclassified person may be issued to a person who submits a completed application to the board with the applicable fee, who is not disqualified pursuant to rule 661—502.4(103), and who is employed by a licensed electrical contractor. Any person who holds a current license issued

by the board, including a special residential electrician license, but excluding other special electrician licenses, may work as an unclassified person without holding an unclassified person license.

502.2(12) In lieu of renewal of the active master electrician license, an inactive master electrician license may be issued to a holder of a master electrician license whose license is due for renewal and who requests placement in inactive status. A holder of an inactive license shall maintain all requirements which would apply for an active master electrician license, except for payment of the fee required for an active license, during the term of the inactive license. If the license holder fails to meet any such requirement during the term of the inactive license, the license holder shall not be entitled to reinstatement of an active license. If the license holder continues to meet all such requirements while holding an inactive license, the license holder may obtain an active master electrician license by surrendering the inactive master electrician license, filing an application for reinstatement, and paying the applicable license fee. The holder of an inactive license who seeks reinstatement of an active license shall not receive any refund of the fee paid for the inactive license. A person who holds an inactive license may not perform work which requires the person to be a holder of that license but may perform work authorized by any active license issued by the board which the person holds.

502.2(13) Retaking an examination. If passage of an examination is a requirement for issuance of a license:

a. An applicant who has taken the examination for a license twice and has failed the examination twice shall wait six months before taking the examination again and shall complete 12 hours of continuing education approved by the board on subjects related to the standards specified in 661—Chapter 504. After satisfying the requirements of this paragraph, the applicant may take the examination two additional times, or a maximum of four times.

b. An applicant who has satisfied the conditions of paragraph “*a*” and who has taken the examination two additional times, or a total of four times, and has failed the examination four times shall wait an additional six months and shall complete an additional 12 hours of continuing education approved by the board on subjects related to the standards specified in 661—Chapter 504 before taking the examination again. After satisfying the requirements of this paragraph, the applicant may take the examination two additional times, or a maximum of six times.

c. An applicant who has satisfied the conditions of paragraph “*b*” and who has taken the examination two additional times, or a total of six times, and has failed the examination six times shall not be permitted to take the examination an additional time unless approved to do so by the board. An applicant who wishes to take an examination after failing it six times shall wait six months and then may petition the board to allow the applicant to take the examination an additional time. The applicant may be required to appear personally before the board when the board is considering the petition.

502.2(14) Reciprocal licensing. A journeyman class A license may be issued, without examination, to a person who holds a license from another state provided that:

a. The board has entered into an agreement with the other state providing for reciprocal issuance of licenses and that the agreement recognizes the equivalency of the examination required for the license issued by the other state and the examination required for the Iowa license to be issued; and

b. The applicant has successfully completed a supervised written examination approved by the other state with a score of 75 or higher in order to obtain the license from the other state; and

c. The applicant holds an applicable license from the other state at the time the application for an Iowa license is filed and has held the applicable license from the other state continuously for one year at the time the application for an Iowa license is filed; and

d. The applicant has submitted:

(1) A completed application for the Iowa license;

(2) A copy of the applicable license from the other state, clearly showing the license number and any other identifying information;

(3) The applicable fee;

(4) The sworn affidavit required under subparagraph 502.2(14)“*e*”(2), if applicable; and

(5) Any other information required by the board; and

e. The applicant has either:

- (1) Completed an approved apprenticeship program; or
- (2) Completed 16,000 hours of electrical work as an electrician licensed by the other state, as documented by submission of a sworn affidavit signed by the applicant.
- [ARC 8396B, IAB 12/16/09, effective 2/1/10; ARC 9234B, IAB 11/17/10, effective 1/1/11; ARC 9626B, IAB 7/27/11, effective 9/1/11; ARC 9811B, IAB 10/19/11, effective 12/1/11; ARC 0120C, IAB 5/16/12, effective 7/1/12]

661—502.3(103) License terms and fees. The following table sets out the length of term of each license and the fee for the license.

License Type	Term	Fee
Electrical Contractor	3 years	\$375
Residential Electrical Contractor	3 years	\$375
Master Electrician, Class A	3 years	\$375
Master Electrician, Class B	3 years	\$375
Residential Master Electrician	3 years	\$375
Journeyman Electrician, Class A	3 years	\$75
Journeyman Electrician, Class B	3 years	\$75
Residential Electrician	3 years	\$75
Special Electrician	3 years	\$75
Apprentice Electrician	1 year	\$20
Unclassified Person	1 year	\$20
Inactive Master Electrician	3 years	\$75

502.3(1) Fees are payable in advance with the application, by check or warrant to the Department of Public Safety. The memo area of the check should read “Electrician License Fees.”

502.3(2) Notice of renewal shall be provided to each licensee no less than 30 days prior to the expiration of the current license.

502.3(3) If a license is issued for less than the period of time specified in the table above, the fee shall be prorated according to the number of months for which the license is issued.

502.3(4) A licensee who is on active military deployment for 91 or more consecutive calendar days during the term of a license may have the license period tolled as follows. “Tolled” means that the expiration date of the license shall be delayed for the period of time during which the license term is tolled.

a. A licensee who is on active military deployment for 91 or more consecutive calendar days during a licensing period may have the license terms tolled for one year.

b. A licensee who is on active military deployment for 366 or more consecutive calendar days during a licensing period may have the license terms tolled for two years.

c. A licensee who is on active military deployment for 91 or more consecutive calendar days but fewer than 366 consecutive calendar days may petition the board to have the license tolled for two years upon a showing of a special hardship which would not be alleviated by tolling the license term for only one year.

d. A licensee who requests that the term of a license be tolled pursuant to this subrule shall provide a copy of military orders showing the beginning and ending dates of the deployment or deployments which are the basis for the request.

502.3(5) A licensee may obtain a replacement license for a license that has been lost. To order a replacement license, the licensee shall notify the board office in writing that the license has been lost and shall provide any information required by the board office, which may include, but is not limited to, the license number, the name of the licensee, and a description of the circumstances of the loss, if known. The fee for issuance of a replacement license shall be \$15.

EXCEPTION: If a licensee who is located in an area covered by a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6 which is currently in force or has been

in force within the previous 90 days certifies to the board that the license was lost as a direct result of conditions which relate to the issuance of the disaster emergency proclamation, the fee for replacement of the license shall be waived.

[ARC 8396B, IAB 12/16/09, effective 2/1/10; ARC 9234B, IAB 11/17/10, effective 1/1/11]

661—502.4(103) Disqualifications for licensure. An application for a license shall be denied if any of the following apply:

502.4(1) The applicant fails to meet the requirements for the license for which the applicant has applied or the applicant fails to provide adequate documentation of any requirement.

502.4(2) The applicant has previously had a license revoked or suspended by the board, and the circumstances which formed the basis of the revocation or suspension have not been corrected. If a license was revoked or suspended and conditions were imposed for the restoration of the license, licensure shall be denied unless those conditions have been met.

502.4(3) The applicant has been denied, for cause, a license to work, or a license as an electrician has been revoked, for cause, in any other state or political subdivision and the applicant has not subsequently received a license from the state or political subdivision which denied or revoked the license. An applicant who has been denied a license pursuant to this provision may apply to the board for a license and, upon a showing of evidence satisfactory to the board that the condition or conditions which led to the denial or revocation no longer apply, the board may grant the license to the applicant.

502.4(4) The applicant falsifies or fails to provide any information requested in connection with the application or falsifies any other information provided to the board in support of the application.

502.4(5) The applicant may be denied a license if the applicant has previously been convicted of a criminal offense involving, but not limited to, fraud, misrepresentation, arson or theft, or if the applicant is currently delinquent in paying employment taxes to the state of Iowa or the United States. If the denial is based upon conviction of a criminal offense, the board shall examine the specific circumstances of the offense and may grant the license if, in the judgment of the board, sufficient time has passed since the conviction and there is no further evidence of criminal conduct on the part of the applicant.

502.4(6) The applicant has unpaid fees due to the board which are 120 days or more past due. The license for which the applicant applied may be issued after the fees are paid if the applicant is not otherwise disqualified from obtaining the license.

[ARC 8396B, IAB 12/16/09, effective 2/1/10; ARC 0120C, IAB 5/16/12, effective 7/1/12]

661—502.5(103) License application. Any person seeking a license from the board shall submit a completed application to the board accompanied by the applicable fee payable by check, money order, or warrant to the Iowa Department of Public Safety. The memo area of the check should read “Electrician Licensing Fees.” The application shall be submitted on the form prescribed by the board, which may be obtained from the board office.

[ARC 8396B, IAB 12/16/09, effective 2/1/10]

661—502.6(103) Restriction of use of class B licenses by political subdivisions. A political subdivision may disallow or restrict the use of a class B license to perform electrical work within the geographic limits of that subdivision through adoption of a local ordinance. A copy of any such ordinance shall be filed with the board office prior to the effective date of the ordinance. If a class B license holder held a license issued or recognized by a political subdivision on December 31, 2007, that political subdivision may not restrict the license holder from performing work which would have been permitted under the terms of the license issued or recognized by the political subdivision.

EXCEPTION 1: An ordinance restricting or disallowing electrical work by holders of class B licenses shall not apply to work which is not subject to the issuance of permits by the political subdivision.

EXCEPTION 2: An ordinance restricting or disallowing electrical work by holders of class B licenses which was passed prior to January 1, 2008, shall be filed with the board as soon as practicable and, in any case, no later than April 1, 2008.

[ARC 8396B, IAB 12/16/09, effective 2/1/10]

661—502.7(103) Financial responsibility. Any holder of an electrical contractor license or any holder of an electrician license who is not employed by a licensed electrical contractor and who contracts to provide electrical work which requires a license issued pursuant to 661—Chapters 500 through 503 shall, at all times, maintain insurance coverage as provided in this rule.

502.7(1) The licensee shall maintain general and complete operations liability insurance in the amount of at least \$1 million for all work performed which requires licensing pursuant to 661—Chapters 500 through 503.

a. The carrier of any insurance coverage maintained by the licensee to meet this requirement shall notify the board 30 days prior to the effective date of cancellation or reduction of the coverage.

b. The licensee shall cease operation immediately if the insurance coverage required by this rule is no longer in force and other insurance coverage meeting the requirements of this rule is not in force. A licensee shall not initiate any electrical work which cannot reasonably be expected to be completed prior to the effective date of the cancellation of the insurance coverage required by this rule and of which the licensee has received notice, unless new insurance coverage meeting the requirements of this rule has been obtained and will be in force upon cancellation of the prior coverage.

502.7(2) Reserved.

[ARC 8396B, IAB 12/16/09, effective 2/1/10]

These rules are intended to implement 2007 Iowa Acts, chapter 197.

[Filed emergency 12/17/07—published 1/16/08, effective 1/1/08]

[Filed ARC 8396B (Notice ARC 8160B, IAB 9/23/09), IAB 12/16/09, effective 2/1/10]

[Filed ARC 9234B (Notice ARC 9099B, IAB 9/22/10), IAB 11/17/10, effective 1/1/11]

[Filed ARC 9626B (Notice ARC 9515B, IAB 5/18/11), IAB 7/27/11, effective 9/1/11]

[Filed ARC 9811B (Notice ARC 9652B, IAB 8/10/11), IAB 10/19/11, effective 12/1/11]

[Filed ARC 0120C (Notice ARC 0038C, IAB 3/7/12), IAB 5/16/12, effective 7/1/12]

CHAPTER 552
ELECTRICAL INSPECTION PROGRAM—PERMITS AND INSPECTIONS

661—552.1(103) Required permits and inspections.

552.1(1) Permits and inspections are required for any of the following electrical installations that are initiated on or after February 1, 2009:

a. All new electrical installations for commercial or industrial applications, including installations both inside and outside buildings, and for public-use buildings and facilities and any installation at the request of the owner.

b. All new electrical installations for residential applications in excess of single-family residential applications.

c. All new electrical installations for single-family residential applications requiring new electrical service equipment.

d. Any existing electrical installation observed during inspection which constitutes an electrical hazard. Existing installations shall not be deemed to constitute electrical hazards if the wiring was originally installed in accordance with the electrical code in force at the time of installation and has been maintained in that condition.

e. Inspections of alarm system installations, rules for which are intended to be adopted as new 661—Chapter 560.

EXCEPTION 1:[See Objection at end of chapter] Installations in political subdivisions which perform electrical inspections and which are inspected by the political subdivision are not required to be inspected by the state electrical inspection program. Any installation which is subject to inspection and is on property owned by the state or an agency of the state shall be inspected by the state electrical inspection program. An electrical installation on a farm which is located outside the corporate limits of any municipal corporation (city) shall not be inspected by a political subdivision, shall require a state electrical permit, and may be subject to a state electrical inspection, unless the installation is subject to Exception 2 or Exception 3.

EXCEPTION 2: Any electrical work which is limited to routine maintenance shall not require an inspection.

EXCEPTION 3: Neither a permit nor an inspection is required for an electrical installation which meets all of the following criteria:

1. The installation is legally performed by a master electrician, journeyman electrician, or apprentice electrician working under the direct supervision of a master or journeyman electrician.

2. The installation to be performed does not in any way involve work within an existing or new switchboard or panel board.

3. The installation to be performed does not involve over-current protection of more than 30 amperes.

4. The installation to be performed does not involve any electrical line-to-ground circuit of more than 277 volts, single phase.

552.1(2) The owner of a property on which multiple electrical installations may be performed during a 12-month period may apply for an annual permit to cover all such installations. The holder of an annual permit shall maintain a log of all installations performed pursuant to the annual permit. The owner shall cause the electrical inspection program to be notified of any such installation requiring an inspection and shall be subject to fees for such inspections as though an individual permit had been issued for each installation requiring an inspection. The fee for an annual permit shall be \$100. The log shall be available to an electrical inspector on the request of the inspector.

[ARC 8396B, IAB 12/16/09, effective 2/1/10]

661—552.2(103) Request for inspection. Prior to commencement of any electrical installation requiring an inspection, the person making such installation shall notify the electrical inspection program of the installation by applying for a permit, unless the installation is covered by an annual

permit issued pursuant to subrule 552.1(2), and shall request an inspection of the installation through one of the following methods:

552.2(1) An inspection may be requested by completing and electronically submitting a Request for Permit form, available on the Web site of the electrical inspection program. Payment of the permit and inspection fees shall be submitted with the form in accordance with the instructions on the electrical inspection section Web site.

NOTE: The Web site to obtain, complete, and submit a Request for Permit form is, as of October 29, 2008: www.dps.state.ia.us/fm/electrical/inspection/.

552.2(2) An inspection may be requested by completing a Request for Inspection form and mailing it to the electrical inspection section as provided in rule 661—550.2(103). The Request for Inspection form may be obtained upon request to the electrical inspection section or from the Web site of the electrical inspection program. If a Request for Inspection form is submitted by mail, it shall be postmarked no less than seven days prior to the commencement of the installation.

552.2(3) An inspection may be requested by completing a Request for Inspection form and submitting it by fax transmission to the electrical inspection section at (515)725-6151. The Request for Inspection form may be obtained upon request to the electrical inspection section or from the Web site of the electrical inspection program.

552.2(4) Modification of permits and failure to pay inspection fees. Inspection fees will normally be paid at the time a permit is obtained. However, additional fees may apply if a permit is modified by an inspector, based upon inspection of the electrical installation. The person who obtained the original permit shall be notified immediately by the inspector of the modification and of the amount of any additional fees which are due. Any additional fees shall be due at the time the person responsible for payment receives notification of modification of the permit.

a. If an additional fee or portion of the fee is more than 60 days past due, the staff of the board shall notify the person responsible for payment of the fee of the necessity of promptly making the payment.

b. If an additional fee or portion of the fee is more than 120 days past due, the secretary of the board may suspend the ability of the person responsible for the payment to obtain inspection permits. The secretary shall restore the person's ability to obtain permits when payment of the past due amount has been received. Suspension of a person's ability to obtain permits may be appealed to the board as provided in rule 661—503.4(103).

c. If payment of a fee or portion of a fee is more than 180 days past due, the board may refer the debt for collection to the department of revenue pursuant to Iowa Code chapter 272D.

[ARC 8396B, IAB 12/16/09, effective 2/1/10; ARC 0120C, IAB 5/16/12, effective 7/1/12]

661—552.3(103) Scheduling of inspections. Subject to the availability of electrical inspectors, the electrical inspector whose territory includes the location of a requested inspection shall schedule the requested inspection to be completed within three business days of the receipt of the request. If an inspection for which a timely request has been made is not completed within three business days of the completion of the installation, a licensee who completed the installation may energize any new circuits included in the installation, although the installation remains subject to condemnation and disconnection if found to be out of compliance with any applicable provision of 661—Chapter 504 when inspected.

661—552.4(103) Report of inspection. After the completion of an inspection, the inspector shall issue an inspection report on a form prescribed by the board. The report shall indicate the results of the inspection, which may be any of the following:

552.4(1) Approval. If the inspector finds that the installation is in compliance with applicable requirements, the inspector shall issue a report indicating that the installation is approved.

552.4(2) Order of correction. If the inspector finds that the installation is not in compliance with applicable requirements but does not present an imminent threat to the health or safety of any person, the inspector shall issue an order of correction, prescribing a time frame during which corrective action shall be taken by the licensee responsible for the installation to bring the installation fully into compliance.

552.4(3) Order of disconnection. If the inspector finds that the installation is not in compliance with applicable requirements and presents an imminent threat to the health or safety of any person, the inspector shall issue an order of disconnection, requiring that the installation be disconnected until corrective action has been taken which brings the installation into full compliance with applicable requirements. The installation shall not be reconnected until corrective action has been completed and the corrected installation has been approved by an inspector as in compliance with all applicable requirements. The inspector issuing an order of disconnection shall notify the utility providing electrical service to the location of the order and shall notify the utility when the order of disconnection is no longer effective.

661—552.5(103) Appeals. An order of correction or an order of disconnection may be appealed. However, an order of disconnection shall be complied with immediately, and the installation shall not be reconnected pending the outcome of the appeal.

552.5(1) A person who has received an order of correction or disconnection may request an informal appeal to the chief electrical inspector within 14 days of receiving the order by contacting the electrical inspection section by telephone, fax, E-mail, or mail. The informal appeal may be heard in any manner agreed to by the person filing the appeal and the chief electrical inspector. If the order is upheld by the chief electrical inspector, the person receiving the order may file a formal appeal pursuant to subrule 552.5(2).

552.5(2) A person who has received an order of correction or disconnection may file a request for a formal appeal to the board within 30 days of receiving the order or, if the person has filed a request for an informal appeal, within 30 days of having been notified that the chief electrical inspector has upheld the order. Formal appeals shall be processed as provided in 661—Chapter 10, except that wherever “commissioner” or “department of public safety” appears in those rules, “electrical examining board” shall be substituted.

These rules are intended to implement 2007 Iowa Acts, chapter 197.

[Filed 10/29/08, Notice 9/24/08—published 11/19/08, effective 1/1/09]

[Filed emergency 11/23/08—published 12/17/08, effective 1/1/09]

[Filed ARC 8396B (Notice ARC 8160B, IAB 9/23/09), IAB 12/16/09, effective 2/1/10]

[Editorial change: IAC Supplement 2/8/12]

[Filed ARC 0120C (Notice ARC 0038C, IAB 3/7/12), IAB 5/16/12, effective 7/1/12]

OBJECTION



TERRY E. BRANSTAD
GOVERNOR

OFFICE OF THE GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

January 23, 2012

Commissioner Larry Noble
Iowa Department of Public Safety
Department of Public Safety Headquarters Building
215 E. 7th Street
Des Moines, IA 50319

Dear Commissioner Noble:

I object to the portions of Iowa Admin. Code r. 661-551.2 and 661-552.1 which regulate electrical installations on farms as defined in Iowa Code §103.1. These filings were adopted by the Electrical Examining Board and published as part of ARC 7346B in XXXI IAB 11 (11-19-2008) and ARC 8396B in XXXII IAB 13 (12-16-2009), respectively.

The Electrical Examining Board has gone beyond their statutory authority. Iowa Code chapter 103 does not grant authority to the Electrical Examining Board to adopt rules to regulate electrical installations on farms by requiring a request for an inspection, a permit and/or an inspection. I find that the Electrical Examining Board went beyond the authority delegated to the agency when it included farm electrical installations within the definition of a "commercial installation" in Iowa Admin. Code r. 661-551.2. I further object to that portion of the third sentence of EXCEPTION 1 to Iowa Admin. Code r. 661-552.1(1) which requires a state electrical permit and/or an electrical inspection for a farm electrical installation as it is beyond the delegated authority of the agency.

The permit and inspection requirements for electrical installations on farms are unreasonable, arbitrary and capricious for several reasons. These rules increase the regulatory burden on farms and farmers. This power-grab by the Electrical Examining Board hurts hard-working Iowa farmers. It leads to unwanted government intrusion. It imposes the very costs on farmers that the legislature intended to protect them from when it created common-sense exemption for farmers. (2007 Iowa Acts, chapter 197). This rule hurts the opportunity of hard-working Iowa farmers to earn a living, free from undue bureaucratic interference. These over-reaching rules harm economic opportunities in agriculture and job growth in Iowa.

The portions of the Iowa Administrative Code r. 661-551.2 and 661-552.1 as described herein, are deemed to be unreasonable, arbitrary, capricious, or otherwise beyond the authority delegated to the agency. This letter constitutes notification of my objection to the above referenced rules as required by Iowa Code §17A.4(6).

Certified as a true and correct copy of my objection this 23rd day of January 2012, by:



Terry E. Branstad, Governor



cc: Electrical Examining Board
Administrative Code Editor

Objection filed January 23, 2012

REVENUE DEPARTMENT[701]

Created by 1986 Iowa Acts, Chapter 1245.

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CHAPTER 151
COLLECTION OF DEBTS OWED THE STATE
OF IOWA OR A STATE AGENCY

701—151.1(421) Definitions. For purposes of this chapter, the following definitions shall govern:

“*Debtor*” means any person having a delinquent account, charge, fee, loan, or other indebtedness due the state of Iowa or any state agency.

“*Department*” means the Iowa department of revenue or the director of the Iowa department of revenue and the director’s representative.

“*Director*” is the director of revenue.

“*Liability*” or “*debt*” means any liquidated sum due and owing to the state of Iowa or any state agency which has accrued through contract, subrogation, tort, operation of law, or any legal theory regardless of whether there is an outstanding judgment for that sum.

“*Person*” or “*entity*” means individual, corporation, business trust, estate, trust, partnership or association, limited liability company, or any other legal entity, but does not include a state agency.

“*State agency*” or “*agency*” means a board, commission, department, including the department of revenue, or other administrative office or unit of the state of Iowa. “State agency” does not include the general assembly, the governor, or any political subdivision of the state, or its offices and units.

701—151.2(421) Scope and purpose. The purpose of these rules is to improve collection efforts by establishing a centralized collection system in the department for use by state agencies to collect delinquent accounts.

701—151.3(421) Participation guidelines. Those state agencies qualified to use this chapter’s collection provisions should utilize those provisions when it is cost-effective to do so. Final determination regarding whether or not it will be cost-effective to collect any debt owed will be at the discretion of the director. Generally, it will not be cost-effective to pursue collection of a debt if the total anticipated collection cost will exceed the amount of the claim that could reasonably be expected to be realized. The cost-effectiveness criteria which the director applies will not be the same for every agency. Circumstances differ among agencies.

701—151.4(421) Duties of the agency. The agency seeking the use of the centralized collection system shall have the following duties regarding the department and debtors.

151.4(1) Notification to the department. The agencies must provide a list of debtors to the department of revenue. This list must be in a format and type prescribed by the department and include information relevant to the identification of the debtor and the source and amount of the debt. The agencies shall terminate all collection activities once notification is given to the department.

151.4(2) Change in status of debt. A state agency which has provided liability information to the department of revenue must notify the department immediately of any change in the status of a debt. This notification shall be made no later than ten calendar days from the occurrence of the change. Change in status may come from payment of the debt or liability, invalidation of the liability, alternate payment arrangements with the debtor, bankruptcy, or other factors.

701—151.5(421) Duties of the department—performance of collection. The department will develop procedures for administering the collection program on an agency basis. Procedures may vary in order to achieve the greatest efficiency in administering the collection program for each agency.

701—151.6(421) Payment of collected amounts. Payments of collected amounts shall be made by the department monthly, but other arrangements can be made if agency requirements specify a different time period. Payments will be made to the agency, to the general fund, split between the two, or as required by the agency depending on the circumstances of each agency.

701—151.7(421) Reimbursement for collection of liabilities. Costs incurred by the department in administering the collection program will be charged to the state agency requesting collection. The costs will be charged to the agency or deducted from the gross proceeds collected whichever the director determines is reasonable based on the requesting agency's circumstances. Costs may include direct expenses such as salaries, travel, telephone, supplies, equipment, and system modification and development costs; or indirect costs such as space, security, or utility costs. If the above-described procedure is prohibited by paramount state or federal law, the director shall allow charges, deductions, or reimbursement in a manner which conforms to the paramount law.

701—151.8(421) Confidentiality of information. Information shared between state agencies shall be deemed confidential and shall be disclosed only to the extent that sufficient information is given that is relevant to the identification of persons liable to state agencies. The confidentiality provisions of Iowa Code sections 422.20 and 422.72 do not apply to tax information contained in the centralized computer data bank. The information is to be used for purpose of debt collection or license application or renewal.

701—151.9(421) Subpoena of records from public or private utility companies. The director may, to the extent permissible by federal law, subpoena certain records held by a public or private utility company with respect to an individual who has a debt or obligation placed with the centralized collection unit of the department. This authority may be used only after reasonable efforts have been made by the centralized collection unit of the department to locate the individual.

151.9(1) Definitions.

a. "Public or private utility company" means a public utility, cable, video, or satellite television company, cellular telephone company, or Internet service provider.

b. "Reasonable efforts," for purposes of this rule, will be considered complete when the following procedures have been performed by the department:

(1) The department has received returned and undeliverable mail sent to the individual's most recent address known to the department; and

(2) The department has attempted to reach the individual at the listed telephone number and discovered that the telephone number is incorrect or the telephone has been disconnected.

c. "Utility" means the same as "public or private utility company" as defined in paragraph 151.9(1) "a."

151.9(2) Procedure for issuing a subpoena; data transfer.

a. The department will contact the utility to obtain agreement upon the subpoena process; the form, format and transmission method of a secure data file; and the schedule for both the subpoena and the data.

b. The department shall submit the subpoena to the utility's designated recipient on or before the date a secure data file is submitted for processing. The subpoena will include the director's authority to make the request, the name of the file submitted for processing, the information to be provided for each individual, the expected response date, and the department's contact information. The data file provided to the utility by the department will include social security numbers, names, and last-known addresses in the mutually agreed-upon format.

c. Upon receipt of the department's data file, the utility will match the data file against its current customer information and return to the department the current last name, first name, middle name, address 1, address 2, city, state, ZIP code and telephone number for any current customer information that matches the social security number and designated characters of the last name as provided by the department. The department will not request or require any information from the utility other than the current address and telephone number.

d. Within 30 days of receiving the department's data file, the utility will process and return the data file to the department using the agreed-upon secure file transfer process.

e. When the data file is returned, the department will match the returned data with the social security number and designated characters of the current customer's last name before updating its collections system with the new address or telephone number.

f. The department will use the address and telephone number received from the utility to contact the individual for collection purposes.

151.9(3) Confidentiality. The utility must keep confidential all records received from the department. After the department has received the requested information from the utility, the utility must delete the data files it received in a secure manner. The department must keep confidential all records received from the utility in compliance with all applicable state and federal laws regarding individual privacy and the privacy rights of public and private utility companies.

This rule is intended to implement Iowa Code section 421.17(32).

[ARC 0124C, IAB 5/16/12, effective 6/20/12]

These rules are intended to implement Iowa Code sections 421.17, 422.20, and 422.72.

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